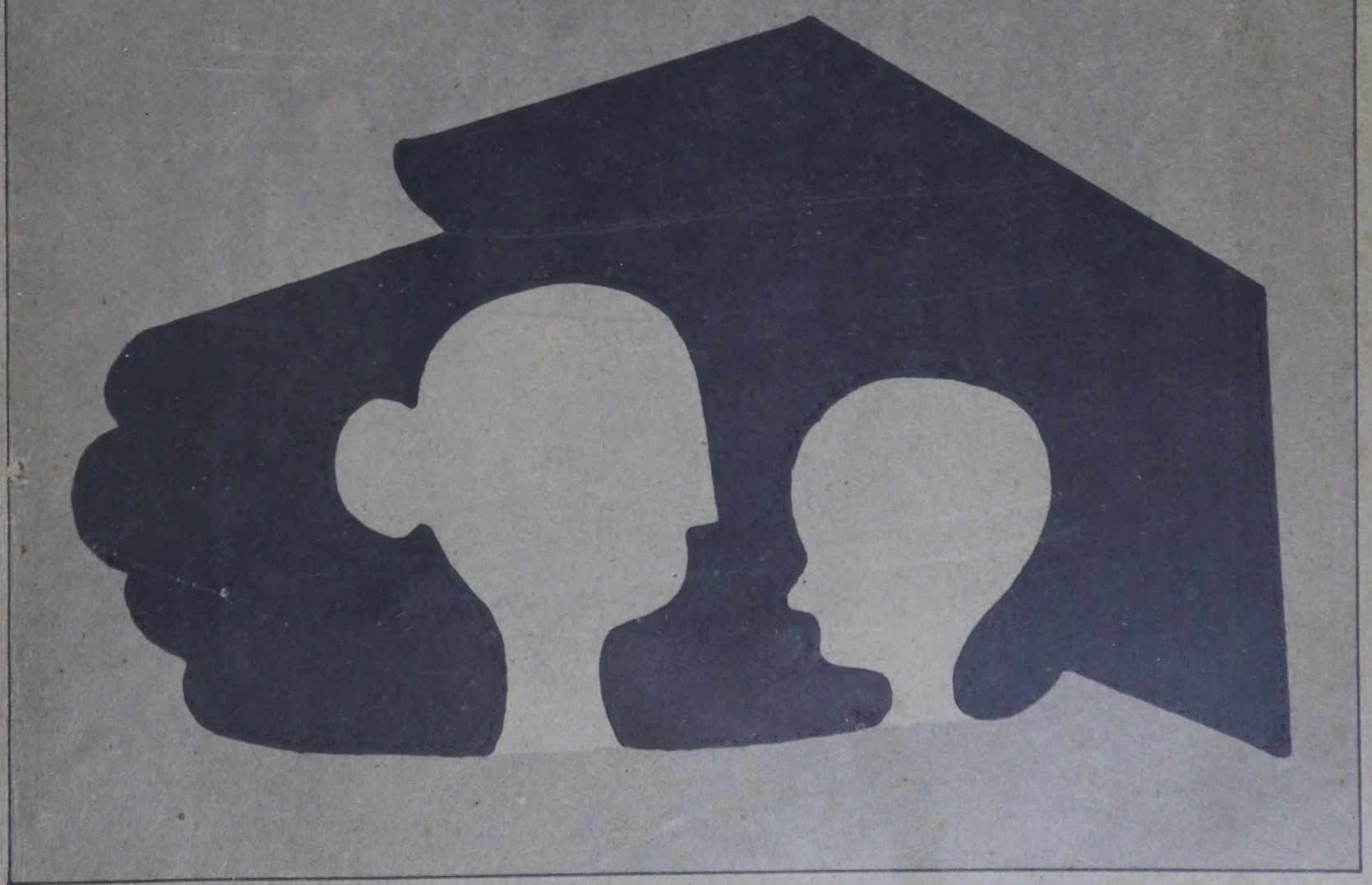
LEARNING FOR HEALTH CARE



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CONTENTS

PREFACE

This study originated from the experiences of various governmental and non-governmental efforts intended to promote community involvement in Primary Health Care. Some of the insights gained in an earlier study on a similar theme conducted by the International Council for Adult Education (ICAE) provided the initial base for the study.

However, in the course of planning this study during 1982-83, it became clear that existing documentation on the use of adult non-formal education in promoting and sustaining community involvement in Primary Health Care in India did not exist. On the other hand, there were several experiences available within the country which have significantly used non-formal education in this area.

We decided to document these cases through the process of Participatory Research (PR) such that, members of the project team, as well as local population, become involved in a systematic reflection of their work. Thus, we had hoped for, and received, active engagement of the selected projects in the entire documentation process.

This volume essentially represents the work done by various teams in preparing the case studies and the collective analysis of these case studies carried out by a larger group of people in September 1985. Sheela Patel (now with SPARC, Bombay) worked on the case study of Nagpada Neighbourhood House, Bombay; Gabriele Dietrich and Fatima Burnad worked on the case study of SRED, Tamilnadu; Ulhas Jajoo and Anita Dighe worked on the Sevagram case study; Narendra Gupta and Nandini Narula prepared the case study of PRAYAS and Provat Goswami and Nandini Narula prepared the CINI case study.

We are grateful to them for their immense contribution in this effort. Rajesh Tandon prepared the draft of this volume.

This volume is intended to present these reflections, highlighting the nature and process of non-formal education. A more popular manual on this theme is also under preparation.

We are grateful to Ford Foundation, New Delhi for their support in conducting this study.

January 1986.
New Delhi.

INTRODUCTION

Background

Since the 1978 Alma Ata declaration on Primary Health Care, various governmental and non-governmental agencies have planned and implemented a series of programmes on Primary Health Care throughout the world. This thrust has also been implemented in India.

The very meaning of Primary Health Care entails community involvement in maintaining its own health. In fact, ordinary people taking responsibility for their own health is a basic tenet of Primary Health Care. Thus, Primary Health Care combines low cost and simple curative approaches with preventive and promotive approaches.

The role of education in sustaining and strengthening community control over their own health has long been recognised as an important element in ensuring implementation of the strategies of Primary Health Care. This educational process has been seen as a basis for initiating programmes of Primary Health Care and methods of shifting responsibility for health away from experts and professionals to ordinary people.

However, much of the health education efforts in the country seem to have fallen into the trap of dispensing education in the same way as injections and pills are dispensed. Thus health education implies "dumping" information onto the members of the community hoping that this will bring about the desired change in their attitudes and behaviours.

It has increasingly become clear that this type of health education cannot sustain and start community involvement in Primary Health Care programmes. In fact, this educational method is in contradiction to the very principles of Primary Health Care. Unless alternative health educational methodology is practised, it is unlikely that primary health care can be accomplished and community involvement sustained.

It is in this context that the need was felt to document those non-governmental examples where adult non-formal educational processes have been effectively used. It was felt that these innovative experiments should be available for learning by others and such a documentation of case studies was seen as a possible mechanism to facilitate this learning.

Overall Objective

The overall objective of the study was to examine the use of adult non-formal educational strategies in promoting community participation such that Primary Health Care objectives are accomplished.

Specific Objectives

a) To identify and document the experiences of those primary health projects where adult non-formal education strategies have been used to promote and strengthen community participation, particularly that of women;

b) To identify factors that seem to facilitate or hinder promotion of community participation in primary health through such educational efforts.

Study Questions

While it was difficult to establish hypotheses at that stage, some key questions were focused on in this study:

a) In a primary health project which is characterized by community participation, what adult non-formal educational methods have been used?

b) How do adult non-formal educational approaches assist in promoting and strengthening community participation for accomplishing objectives of the primary health care efforts?

c) Given the special focus on women and children, do these educational methods take into account their unique needs and contributions?

d) How are culturally appropriate educational methods (e.g., theatre, songs, etc.) evolved in promoting participation in and for health?

e) What kind of training do field staff have in utilizing such educational methods to catalyze and sustain community participation in primary health care?

Selection Criteria

Based on these questions, the following criteria were used in identifying suitable primary health projects in the country:

i) Community participation was a key characteristic of the project;

ii) Adult non-formal education methods have been utilized in the project;

iii) The project can be exclusively primary health focused or it can have a broader, integrated focus with health as a major component;

iv) The project can be either voluntary or governmental.

Methodology

A broad outline of this study proposal was first circulated to about 20 projects and programmes of primary health care where non-formal education process seems to have been effectively utilized and community involvement sustained. This initial identification was done from information available with various health networks (like VHAI).

Based on the response of these projects, and taking into consideration regional placements, five examples were identified for documentation.

Since the methodology of documentation was seen as that of PR, it was important to discuss with each project how they felt they could benefit from this documentation process. This discussion also included consideration of creating a team of case study writers for each case study which comprised of project staff as well as an external person.

These discussions culminated in a planning meeting held in August 1984 where each team from all the five examples sat together to discuss the overall thrust of the study as well as to develop individual plans. These discussions further clarified a

concrete focus of the case study documentation. It was agreed that while some of the study questions would remain common to all case studies, each one could also add some additional questions based on their needs. Similarly it was felt that the style in which a case study will be prepared may vary because of the varying nature of the team.

Over the next nine months these teams worked in the field to collect information, to hold meetings and discussions and to systematise their experiences in each example. The process of documentation in the field varied considerably from example to example. In one case, the entire community of several villages actively got involved in reflection and systematisation.

Once the draft case study was ready, a meeting of 22 persons was held in mid-September 1985. In this meeting, each team presented their case study and there was collective reflection of each example. This was followed by a general comparative reflection of all the five cases. The meeting also discussed the nature of the final report and further steps in the process. Revised drafts were then circulated to various teams and the final report published thereafter.

Outcomes

While the next section gives details about the outcomes of the content of the study, it may be useful to briefly mention some of the outcomes related to the PR methodology utilized in this documentation process.

In three of the five examples, the documentation methodology included local people, besides the project staff. In the remaining that was not fully possible. However, in each case, several meetings within the project staff were held to discuss plans for the initial draft.

In some cases, there was an initial apprehension about the entire documentation process and the project team was unsure if this would be a source of learning for them. Yet, at the end of this, each team felt that it was an exciting experience and a learning process for them. The very act of documentation forced them to reflect systematically about their work and to take their analysis to a deeper level.

As one participant put it, 'if the process of this experience has any value for us, then it becomes a process for our ongoing future use.' We believe that this indeed has happened in some of these cases.

CASE STUDIES

In this section, the five case studies are presented in detail. These are :

- Slum Dwellers and Health - an experience of Bombay.
- Women's Organisation and Health - an experience in Tamil Nadu.
- Health Insurance Scheme - an experience in Maharashtra.
- Tribals and Health Care - with tribals in Rajasthan.
- Maternal and Child Health - an experience in West Bengal.

At the end of each case study, a separate box highlights important features of that case study. These features were identified during the collective reflection process.

SLUM DWELLERS AND HEALTH

Background

Nagpada Neighbourhood House (NNH) Bombay is more than 50 years old organisation. It had been a trend-setter till the sixties in the field of providing services to the urban poor. The basic approach underlined throughout this period was creating alternate service infrastructure. With changing times and expansion of service delivery system of the government, the organisation's earlier glory started fading.

NNH was running a medical centre, at considerable cost, as one of its important activities. The rate of utilisation of this medical centre by the community gradually came to a negligible level. There had been several evaluations undertaken and suggestions made, but all of these could not move beyond the concern for improving the facilities at the medical centre. As a result, the orientation remained that of providing curative medical services and expecting people to utilise it at their own initiative.

The efforts of the past, in a way, failed to assess the changing needs of the community, and to evaluate its role as a community centre.

In 1978, when I became the programme organiser of NNH, there was an internal evaluation of the programme. After considerable discussion we acknowledged that there were many basic flaws in our assumptions. If we persisted on operating along these lines, then we would be competing with private practitioners and municipal hospitals. And we were bound to come a poor second, as we would never be able to match their resources. We found a new sense of direction when we re-examined our role as a voluntary organisation.

First of all, it was very difficult for the staff of NNH to accept that we were providing medication to the type of families who were choosing to come to us rather than go to the private practitioner. Most of the ante-natal programmes were not getting much response because now the patients registered in maternity hospitals.

We were all very diffused in what we meant to present as the focus of our outreach. For instance, we would talk about preventive care, but we discussed in our strategy about promotive health

care, and all our services were of curative nature. We decided we had nothing to lose in trying different approaches to bring change.

New Directions

We had reached a consensus that we wanted to approach those families who were residents of the community, hardly ever went to the doctors, and were very poor. We also wanted to know what their needs are, why they do not come to NNH. It was therefore decided that we would go to the various tenements in the area, and we would work out an instant checkup of the members of the community, discuss the various causes of these problems; and follow-up any further illnesses. We also decided to talk to the women about home remedies, self medication, and encourage people to use NNH for further follow-up.

As a result, we began a tentative but gradually well- established contact with the people of the area. We began to understand what the major concerns of the people were, and how to deal with them.

We were also able to see that despite the best of intentions, there were several gaps in communications. These were at various levels: between patient and doctor (when symptoms were indicated), between doctor and patient (when the diagnosis were made), and among people from the community when they related this interaction.

We were able to bring about several changes between 1978 and 1980 as a result of which people who had never used the centre began to come. New schedules of work were established, and along with treatment being given, several dimensions were added to the work of the clinic. Also, explanations were given to help people understand what they were suffering from, and to understand how to take treatment.

As this was established, we also provided similar facilities to school children. We would get in touch with the school, and inform them about the project. Then class by class, we would be involved in medical and other types of examinations with children which would include measuring heights and weights, discussing food fads, common ailments, etc. After each batch was over, the social worker would sit with the doctor and work out trends and commonalities. After that, there would be a meeting with the children, in which they would be told about major problems the class had.

For instance, most of the children had food fads, hated vegetables, and had dental cavities. Instead of telling them what must be done, they were told why it occurred and what could be done to resolve it. Similarly with the parents, each child's problems were discussed and solutions suggested, and the doctor and social worker would then give them a talk on simple home remedies, signs to be concerned about, simple promotive measures to take, and how to analyse family nutrition.

Lessons Learnt

First of all, all our experiences indicated that **to see health care as a one-way communication was wrong.** It was not a process where a body was presented to the doctor, and was diagnosed and magically treated. Patients had to fully participate in the treatment of their bodies. It often included treatment of the mind. And unless there was active participation, only the acute and overt symptoms were seen. As a result, it became obvious to us that we needed to see the various episodes when patients seek medical assistance as a chain of events. For instance, doctors have a habit of seeming indifference to patients who are poor.

A fairly routine and regular story is of a patient who goes to the doctor saying she is ill, then doctor asking what other 'taklif' she has, then prescribing medication. General conversation between doctor and patient constantly resounds of words like, 'kamzori', 'Khoon ki kami', and 'takat'. The standard solution is the 'tonic'. Now at this point I also want to state that the doctors who have worked with me are not all indifferent, or uncaring. My discussions with them have shown that very often their enthusiam to work with the poor is defeated by their total lack of exposure to an effective manner of communication with them.

Therefore, we realised that we were all experiencing a resocialisation which was helping us to understand areas of our own limitations and to move ahead trying different alternatives.

Secondly, we faced the reality, that **health was an area which affected the lives of the poor in various traumatic ways.** While it was the area which they least invested in, it became the single most important spending priority at times of illnesses. Usually these illnesses were due to lack of preventive care. Often they arose also out of sheer poverty. Whatever the reason, the unfortunate response that it evoked was that of desperate expenditures. Almost as if lavishly spent money could bring back health. People just blindly did things in crisis. Rarely did they learn any lessons from the previous crisis. And in between the crises, they seemed indifferent.

Since then I have learnt that the over-compensation which is made by over-spending is based on long instilled values, i.e. poverty and its bad luck have heaped these problems on them, and that to save a loved one any amount of money can be borrowed. Also, the seeming indifference really is the facade which hides the total bewilderment that is felt during and after illnesses. Most poor people have vastly differing basis for understanding illnesses.

Thirdly, **health status is a very elusive term.** Apart from hard statistics like mortality, and dire malnutrition, it is very difficult to judge any specific input and its impact on health status. It is also naive to think that in an urban slum, we could control the state of nutrition and hygiene, or for that matter, get people to control these in order to change their health status.

Therefore, we moved in the direction to seek out ways in which we would start a process whereby people could begin with developing greater control over whatever was occurring to them, analyse it, and use it in the future. Gradually, we began to use series of individual experiences to form a new body of knowledge. This made them feel strong enough collectively to seek changes which would improve their health and to take whatever actions were necessary to resolve health problems. **Awarness building through personal experiences was the alternative that we chose.**

Clearer Communication

In 1980, which is around the time we began to move in this direction without really preplanning it, all our joint experiences in dealing with health problems began to get collated. In 1981 when about a hundred families were to have a check-up, the social workers would sit with the doctors, and keep asking both, the doctor and the patient, questions. For instance, when the doctor said that the child had heat boils, unless there was an intervention by the social workers, the conversation would move on to things like medications. Instead, the social workers would ask, why did children get heat boils? Why was the doctor so worried about the boils in the head, rather that near the limbs? Could it be prevented? Was there a home remedy? Often new bits of information related to common problems came up. While waiting for the doctor's check-up, these would be

discussed. Not only did it add to the knowledge of the patient, often the mothers would work this out and ask doctors to confirm it. Sometimes if the women had another reason to which they attributed the illness, they would discuss that. It seemed that often the doctor would also need assistance to decode what the patients or their parents were saying. And since the social worker felt comfortable with both the doctor and the families, it was very easy to play this role.

Another very big gap we found in communication was in the treatment plans. Doctors happily explained, two tablets three times a day, one tablet two times, a tonic once in two days. All information was promptly jumbled. Since most of the mothers were illiterate, written notes made no difference. This problem became very intense especially when we found that anti-biotics had to be given. In several instances, where women have been honest, they have sheepishly stated that they have given irregular doses, too much or too little, and often could not remember. While most would be ready to label this behaviour as irresponsible, I have found that women do not understand the implications of regular doses. Often their lives are such that they are neither present for supervision, nor can they leave instructions. No problems are solved by condemning their behaviour.

There is also a very large gap between what the doctor perceives as serious, and what the parent perceives as serious. Often we have had experiences of women who stated their children had no problems, but in fact, had a variety of chronic ailments. Obviously acute and traumatic problems such as vomiting, festered wounds, high temperatures were very anxiety provoking; while low evening fevers, weakness etc., were not.

We also found that we had to be very careful in discussing the necessity of follow-up. Their past experiences with private practitioners seemed to predispose them to one shot treatment. Therefore, unless the need to see the doctor was emphasised, they would not come.

In the beginning, it meant that we had to try and explain to them all the details as simply as possible and seek their collaboration in the treatment. Often, if one was not careful, it was possible to try and simplify at the cost of reducing the seriousness of the problem. While understanding this we realised that probably this was how the doctors committed major mistakes when they passed TB as weakness and often treated patients as children who might be scared if major illnesses were mentioned.

Women's Groups

Gradually, in 1982, we finally began to set up women's groups from six different areas. These women were mainly heads of their households and were to meet once a month for a period of an hour or so. While we had established no preconceived notions about what to 'teach', we were very sure what we were not going to do. We were not going to focus on any one area of their lives. We kept two main objectives for ourselves.

Firstly, to help women from each area to operate as a collective, and to be supportive of each other at times of crisis. Secondly, to evolve through their own experiences, a meaningful learning experience which over a period of time would become a meaningful alternative to help them face daily crises in life more effectively.

Health had been an area which we would be frequently dwelling on, and there were many suggestions that we start a volunteers training programme. In fact, given the popularity of training programmes in health evolved by various groups in the city, we were very seriously considering this possibility. However, we decided against it. We did have special training prorammes for some members who were from these groups and wished to learn more and were willing to share their knowledge with others in the community. The main reason behind that decision was, that most volunteers' training in health made these persons health workers. We were of the opinion that such a model was relevant in areas where there were no doctors, and hospitals. In Bombay, there were enough basic facilities. What was needed was an orientation to use them.

So whatever basic health education was necessary, should be given to all. Besides, most of the health workers were given some monetary compensation for the work they were doing. That in fact seemed to carry its own implications, and a host of problems rather than advantages. For instance, though this was meant as an honorarium, workers saw it as a wage. This made them identify with the agency rather than with the community.

Finally, I have serious misgivings about sharing any knowledge with a few. In my opinion, it is often the difference in knowledge levels which initiates the process of exploitation. For instance, it has been a very common occurrence in our neighbourhood slums, that whenever somebody needs immediate hospitalisation, the 'dalal', or some intermediary, who has knowledge of how to use the hospital, will do so for a fee. It could well be that by training a few, we were possibly creating a new batch of exploiters; while, in fact, our intention was just the opposite.

However, we did have a group of about 20 women and a group of young persons who were all called volunteers. They met initially twice a week, and gradually once a week, and now meet whenever the need arises. These groups fulfilled dual functions. These were women who were very excited with what was happening in the groups, had tried to utilise this in their lives, found it effective and were keen to learn more. Most of them were either already leaders, or were potential leaders. We utilised this enthusiasm to give them knowledge that they were keen to acquire. For instance, since all of them were from different areas, we found that when they had got over their initial hesitation to talk with each other, they had a lot to learn from each other. This gave us an idea of how we could get all six groups together.

This also provided us live instances to evaluate and analyse, and to become sensitive to the type of problems they faced and how they resolved it. They were encouraged to discuss others' as well as their own problems, and often would go back, talk to other women, and seek the group's assitance to solve some problems. As a result, although they were not formally trained as leaders, or health workers, often they would collectively take on that role, and the entire experience centred around sharing new knowledge rather than just gaining knowledge. Much of the weekly conversation was also to evolve a variety of strategies for communication. Knowing that this was vital, these women became partners in closing the gap of communication. Often, they began to initiate discussions and gradually took over the role of leadership.

These weekly meetings fulfilled our need of finding relevant instances for education. Often we would have spent part of the month assisting a particular woman with her problem, and would draw upon her to relate this experience. Since this experience was live, and the woman known to them, interest in and absorption of knowledge was greater.

Illustrations

The following three illustrations represent different aspects of our work and different issues in health care. They have been presented as stories of individual women and their families, learning and changing over a period of time. The role these women have played in the women's groups and the larger community is also mentioned. The illustration also shows various non-formal education processes that have been used in this effort.

Safeeda and Babu

Safeeda is a widow. She came to Bombay with her husband about nine years ago in search of medical treatment because she could have no children. After a year's stay in Bombay, she did not miscarry after conception and had a child, whom she named ALLA Rakhe, popularly known as Babu.

Subsequently she had another child called Shabbir, who is now three to four years old. She lost her husband soon after this child's birth. She decided to stay in Bombay rather than go to the village. Here, she was able to feed herself and her two children and find work. Besides she was independent and did not need to depend upon the relatives, who were uncaring about the widow.

There were a series of mishappenings which occurred to her one after the other. The most traumatic was the accident of her son Babu. Since she lived on the street, her children sat or played on the pavements, while she went to work. One day, while playing, Babu went to the road, and was run over by a bus. Luckily he escaped with multiple fractures in one leg.

He was immediately taken to the hospital, his leg was set and after two months the cast was removed. He must have been asked to

do some exercises, but she claimed that the doctor did not say so, and as a result, Babu could not put his weight on the leg, which is now slightly bent.

It was at this point that the women's groups were formed and Safeeda joined one of them. In one of the many experience sharing meetings she shared this trauma with the group. Her feeling after the whole experience was that the hospital frightened her, she would not be able to go there on her own, and that nobody there cared for her child. Now, he could not even walk.

This led to a discussion on why such accidents occur, what are the measures possible, what has to be done at such times of crisis. Safeeda then related details of the entire experience, and it became a lesson for the women on how to admit an accident casualty into the hospital. Some very interesting details emerged. For instance, all women would go to the ward boys to seek assistance. The ward boys would seek and negotiate a price for assistance, and make the admission as a favour rendered.

Behaviour of each member of the hospital staff was given special significance. For instance, if the nurse just smiled, then she liked the patient, and she was absolved of all future neglect, under the excuse that she was busy. On the other hand, if any staff yelled at them in the beginning, then they were bad, did not give medication and wanted to do harm to the patient. It almost seemed a form of imprinting of long lasting impressions based on the incidental and initial reactions at the time of crisis.

Since Safeeda stated all this in the group meeting, most of the women felt very comfortable to express their similar experiences. Till that point, we had not 'opiniated' ourselves about the hospital system. Instead we were ready to accept views on this subject at face value. So to start with, we decided that

we would collaborate with Safeeda in initiating investigations about whether Babu would be able to walk.

Over the next three months, we had our first taste of how indifferent the hospital is to the poor. She was on her own in the beginning but after her third visit, in three weeks, she came and asked that one of us accompany her to the hospital. When we went, the first visit was a disaster. Then through a burst of inspiration, one of us chose to act like a doctor, breezed through all the formalities, and demanded something be done.

What occurred after that is history. There were two sets of doctors, one wanted to operate and another did not. Twice he was admitted for surgery and brought back just before the operation. Throughout this period several staff and volunteers accompanied Safeeda to the hospital. While this dialogue between two sets of doctors continued, we all waited very patiently. Finally, when it occurred the second time, there was a furore.

As far as Babu's leg was concerned, the doctors were apologetic, and gave a series of physiotherapy exercises to do. At the same time they seemed curious as to why so many people were interested. At the meetings, proceedings were shared. Interestingly, at that time, many other women who had problems would seek to go along with either volunteers or Safeeda, to the hospitals. Without realising it, Safeeda who considered herself to be helpless and ignorant, began to show others how to use the hospitals. In fact, what began as a tentative strategy is now a regular practice.

For instance, it is now a matter of common standing that no woman goes alone to the hospital, always with a group. As a result, there is less diffidence and many brains working together. Over a period of time, we have been able to understand the hospital

hierarchy and how different OPDs work, so that there is better management of time. People know how to get case papers, what are the hours of various OPDs, and gradually, have evolved a growing confidence in dealing with this large hospital machinery.

We had found that in the past, whenever the patient went wih a letter from the doctor, she was dealt with. At the beginning, we put that to some kind of doctor's code. Gradually, we began to write official sounding letters on a special letter pad, and for being able to understand what the poblem is, we would ask the doctor to reply on the letter stating what the comment was and what the followup was. The result was fantastic. It seemed that the patient felt boosted with the letter, which they considered as special privilege. What the letter did in reality was that it indentified the exact OPD, the doctor whom the patient had to see, and described, although briefly, the nature of the complaint. This made communication clear. Since patients insisted on getting a written reply 'for didi', who wrote the letter, we were able to explain to the patient what exactly was the ailment and what treatment was offered.

During meetings, all these happenings were discussed. Women who had experiences to relate would do so, and with the help of the staff, these experiences were analysed. As a result, there was a definite impact on the second visit to the hospital. In the beginning, the doctors attributed this to us, commenting all the time that we as an agency were taking special care of the patients we sent. However, gradually, as patients took others, demanded the same treatment, wanted explanations, all of us were collectively branded as those 'people from Nagpada'.

Over a period of time, there developed a great feeling of security in consulting with the group about what the doctors said, often when decisions about hospitalisation were to be

taken. Usually, each instance, like Safeeda's, was dealt with on its own, and as many of the neighbours who could be involved were roped in to help out. At the time of meeting they were encouraged to share this with the rest of the women with little help from the staff, so that its various facets could be explained for their educational value.

By implication, rather than by action, we were able to show that government provided services were funded by money from everyone's pocket, and the poor had as much right to the services as the rich. The hospital was not going to open its arms and invite the poor to utilise its facilities. Instead, the poor, who otherwise spent such a large portion of their money on the medicines purchased and given by private practitioners could demand these services from them, if they could understand the medical services, and how to use them.

Sakina Ki Bimari

Sakina is the grand old lady from the Central Railway zhopadpatti'. She is a widow, who has two sons, and several grandchildren, and is a well loved woman, known for being very favourable to her daughters-in-law. Both the staff and the members of the group had labelled Sakina as a hypochondriac. She had a dramatic manner of proclaiming that she was ill. She would then proceed to describe in great detail, all her symptoms, and claim that she could not be cured by any doctor.

In order to understand what was wrong with her, we sent her first to our medical centre. The doctor stated that since she had several symptoms, and some chest inflammation, as well as signs of TB, we should get her screened. And therein began her saga. Veena, a volunteer, assigned the job of assisting patients who needed 'escort' for the first time, went along with her to the

Foras Road TB Clinic. She could barely control her temper, since Sakina proceeded to tell the doctors that there was nothing they could do to make her feel better.

Due to Veena's insistence to ignore Sakina and her big talk, the doctor prescribed a course of antibiotics so that other inflammations could be ruled out. Sakina had to take four large, colourful looking capsules a day for a week. On her return, after a week, other investigations could be made. A fortnight elapsed, and Sakina did not go back. Veena heard about it from the doctor on a visit with another patient. In her enthusiasm, she rushed to Sakina's house, and found that Sakina had no intentions of going back to the clinic. There was a collision between the two stubborn strongly-willed women, and Veena stormed out, came back to the clinic stating that she would have nothing to do with Sakina in the future. She was upset about Sakina's lack of gratitude for all the care and concern that was being showered on her.

In an usual moment of inspiration, there was a meeting of all the persons who were there to share their views on what had just occurred. Most of them shared Veena's views, and would have liked to wash their hands off her. However, my feelings were provoked, and just as the devils' advocate, I began to defend Sakina. It began like a game. And as we got deeper into it, what we were discussing began to sound viable. Maybe, I argued, she is frightened, and is using this big talk as bravado. Or maybe, by always complaining, she gets attention. Maybe for us this is trivial, but of importance to her. In earlier experience sharing, we had seen that unless a woman was very ill, neither she herself nor the family paid any attention to her or sought medical assistance. Often, stress manifested itself in the form of psychosomatic illnesses, and we wanted to acknowledge that it provided women some space. It was not the most effective or

or positive method of seeking attention, but we know the circumstances which lead to this happening.

Anyway, after some hectic discussion, we were all ready to accept that Sakina may have reasons to behave like this, and we need to know how we could help her to overcome it. In a way, in her exaggerated manner, Sakina had crystallized the problems which most women show. We knew we were on the brink of something.

Sakina's group meeting was held the following week. At the meeting, we used TB detection and usage of TB clinic facility as a new topic. A role play was done by the volunteers, and much time was spent on relating experiences of the women's reactions to TB: how women tended to hide that they had TB or that any one in their family had TB. Often, we also explained, that doctors did not tell patients that it was TB and as a result, despite the patient taking treatment, the family did not know the reason.

We went into detailed analysis of why there was stigma attached to TB, hid the fact that certain diseases were prevalent in their homes and we shared the statistics of the wards with them. Everyone listened but did not react. Then as a very routine question, I asked Sakina whether she had gone back to the TB clinic to see the doctor. She was stunned that I should ask her this question in front of the group. When she tried to change the topic, I made a bold statement that I admired her for being one of the first to actually go to the clinic, but I was disappointed with her because she had not gone back. In fact, we were all concerned that she had not and wanted to know the reason.

We all continued in this vein for some time, re-emphasising that she was a very brave and a very smart woman, who was investigating by herself the causes of her various problems. Besides, I added, that since she was a well-admired woman in her slum, her

undertaking this venture would set an example for the rest of the community. Besides if it is TB, is it not better to know that ? Is it not better to treat it rather than to ignore it until it would kill her ? It would not only kill her, but would also infect all her family and neighbours. Poor Sakina, with every good stroke she received, and with every admiring glance she got from the women, she was pushed into a corner. We had gambled on her forthright nature.

Having decided that she would, after all, concede and participate, and become the 'heroine' of the day, she also decided to take over the limelight, and dramatically, took out all the antibiotics and flung them on the 'chattai', saying that she could not swallow them because they were too large. The next fifteen minutes were unbelievably enlightening, and so very dramatic, that in themselves they provided many lessons.

Sakina proceeded to state that she had gone to several doctors, and mentioned almost every well-known private practitioner in the area. She stated that she was disgusted since none of them could give her the kind of medicine she wanted. She did not like injections, they poked. She did not like pills or tablets because she had trouble swallowing them, and she did not like liquids since they tasted like bile. She asked, why there were no other kinds of medications.

Every one sobered down when we came back to reality, that illness was not a joyride, that we did not fall ill out of choice, and often, despite all our efforts, our loved ones did fall ill. Unlike earlier days, with no access to medications, there is some improvement now. We can now feel confident enough to understand what the case is and what to do next. We also know that the methods the doctors use are alien and often frighten us. Is running away the only answer? Making excuses in the start seems okay, but even

that means wastage of precious time. How are we as a group going to deal with this problem ? Are we going to make excuses ? Or are we going to be supportive and help face fears and resolve our problems ? We added another dimension to this matter, and how Veena had initially evaluated Sakina's behaviour, and did not want to have anything to do with her. This then became the basis for indicating to the women that they were also responsible to meet half way when someone agreed to help them, and to treat this as an equal relationship. After all, unless it was meaningful to both, it could not be sustained. It was therefore seen that women were responsible for the manner in which they sought assistance and the manner in which they utilised help, and learnt from that experience for future events.

Subsequently, Sakina completed her course, underwent investigation and found that she had TB. She would now come and grumble, complain, and discuss her treatment. Since we were all involved in this strategy, we all wanted to see Sakina through this trial, and whoever was present listened to her tales. Besides, she knew how to keep an audience involved. We also began to read much about TB, learn from the doctor and discussed it when Sakina was seeking explanations. We discussed about drug resistance. Why they occur? What are the reasons? Or, we would talk of the various regimes, or about detection, symptoms, and so on.

As expected, Sakina began to talk about all that occurred at the centre to her community. Soon she had a couple of people from her slum, tagging along with her, sheepishly stating that they were going for a check-up. Earlier, Sakina wanted an 'escort' but gradually, she relented to taking a note, and soon was going even without it. She would not take anyone with her who would not undergo treatment if found ill. Once she even went to the extent of getting a very ill person from Matunga, stating that he was not

taking medication and needed to be hospitalised. She knew we would help firstly to convince him to go to the hospital, and secondly to admit him, if needed.

This provided us with contents for our women's meeting for the next three months. Whenever Sakina could come, she related these herself. There were others who were also going through the same process and they too assisted in the process of educating the group. Gradually, each women's group took on a commitment to first of all taking their own family for TB check-up by going to the clinic; then to assist in the motivation of at least five families in the vicinity. All those who had already gone to the clinic would volunteer to take their neighbours for the first time, and several others volunteered to come at least once a week to take anyone who wanted to visit the clinic.

As a result, we evolved several small details to make this strategy work. For instance, we worked out that if the people were prepared in advance about what is expected, it was easy. They could complete all investigations when they go with their early morning sputum in air tight bottle, which had a tin lid. That they needed to go at 9.00 a.m., that the X-ray would be collected on the third day, and so on. All these things were repeated on and on, and all those who had TB had to get all their neighbours motivated to check out their health. This served a very valuable function. It fulfilled the preventive functions of screening the neighbours, and since the patient was assisting in this, there was reduced stigma. Patients and the community were now aware that once the treatment was established, the patient would not transmit the illness.

Much later, we also had the government to agree to allow us to become a TB sub-centre and after the initial detection and establishment of the regiment was done, the clinic would give us

the medications to give out. We also made a slide show of Sakina talking about her experience with TB, and just a few months ago, we began a campaign of checking all children under five. With the awareness about TB, and the readiness with which they accepted this programme, we were able to set up a schedule whereby the doctor and other volunteers would go to any slum, and administer the test with the help of the women from each area who came to us for meetings. The local women would gather all the children.

Once the test was administered, they would be told how to check if it was positive, and to bring the child to the clinic to show to the doctor. Since the indication was swelling, this was easy, and many children were detected at an early stage. This lead to screening the whole family again, and starting of the drugs. All women from the community were taught about TB by those who came to the centre. In fact, they were encouraged to bring them along if any questions were left unanswered. This led to many joining up the groups, and attending meetings.

Now for most women, the role of nutrition, environment and poverty in causing TB is fairly clear. While some attempts are made to solve this, each undertakes to check-up each year if she has TB.

We have had many instances of people going to the village, taking drugs with them; also, taking a letter from the doctor about their illness, and seeking information in the village about how treatment can be sought there. They claim to have taught their families about the symptoms, and often accompanied them to the district hospitals, where they claim they talked of how well Bombay hospitals treat the poor, as a means to get similar service there.

Asma decided to have an abortion and a tubectomy

Asma has been staying outside the Centre for several years. She has the most smiling disposition when relating to people on the street. About two years ago, she chatted with me. When groups were formed, she did not know of this as none of the women in that particular pavement were coming. We began to relate to each other only after she became noticebly pregnant. As a result, I asked her whether she had registered in the hospital and she seemed very puzzled about it. She said that she did not know anything about that.

So I suggested that she come to the clinic, and get a check up, and maybe would get some nurse to take her to the hospital. As a result, there was a slow development of our relationship. In the beginning, it created several problems, which occur even now. For instance, she was very theatrical, and on the basis of the fact that she considered herself to be **my friend,** she would prance into the medical department and demand immediate attention.

While I perceived her proprietary behaviour as a cover for her feelings of fear and inadequacy, and allowed her to relate in that manner, the medical staff, at least initially, resented this behaviour. There were many scenes that she created, and very often she was in the wrong, but she would get away.

Anyway, she was registered, but finally when she was ready to deliver, there was a hospital strike, and she delivered in very traumatic circumstances in heavy rain, with the help of her neighbour and 10 year old daughter.

Asma has a daughter from her first marriage whom she brought along to Bombay when she left Bihar. She began to work as a maid

here, when a lady who was also from Bihar advised her that she should get married and even suggested the name of the man.

It seemed that this man was younger than her, had a wife in the village who was not comimg to Bombay; so Asma was his second wife. He was very careless about the way he treated her. In fact, for the whole first year when this baby was born, Asma had to fend totally for herself, and as a result this child was the centre of her existence.

She now arranged to put her older daughter in one of the places where she worked. Although they gave her no money, she lived there, they clothed and fed her. This was Asma's way of removing her from the pavement so that she would be 'safe'. Seeing this struggle that she was going through, I suggested that she try and put her little daughter in the creche so that she would be safe there, instead of either being on the street or with the neighbour. So she agreed. However, within a week of being admitted to the creche, she began fighting with the creche workers and removed her child from the creche. Within two weeks, she wanted admission again.

This time, other children were admitted and there was no place. So every week she would come to check, and sit and chat with me. As a result, she began to meet the other women, attending meetings, and she began to interact with women and absorb many of the happenings in the meetings. Over a period of time, we also became familiar with her very complicated relationship with her husband. It was almost as if he was her third offspring. She would feel hurt whenever he deserted her; when he took money for business and instead went and gambled it, she would rant and rage, throw him out of the house, then invite him back after a few days.

None of us ever understood this behaviour, but we just accepted it. We would argue with her, other women would try to tell her. But she always had ready explanations, and she went on doing what she wanted. She also began to bring her friends from that pavement, who would also come often, and while we found a change in the manner of all these other women, Asma did not change or so we thought.

One meeting, we were discussing the phenomenon whereby women, after resenting the way they were treated with lesser priority than the boys in the family, proceeded to do the same in their adult life. Women shared various examples of this attitude, and there was a lively discussion about how women had to have as many girls as were chanced to be born before they got the son. Since we had already discussed the modern city culture, and its effect on sons who never look after their parents, woman at least in the discussion agreed that it was better to nurture daughters who took more care of their parents as compared to the sons.

When I came to work the next day, Asma was there with a grim face. She said she had found out that she was pregnant, and while her husband was very happy about this because he hoped to have a son, she did not want to have this child. So she wanted to know where she could go for an abortion. I was a little worried, as I did not want her to be carried away by group discussions, and hastily take on a course of action which she might regret later. So instead I asked her to finish her work and come in the afternoon. When she came, there were several women who were already there for other work, so we all gathered and I asked Asma to explain to us why she wanted to have a abortion.

She had figured out that she had just finished two very harrowing years of her life, giving life to a child, and only now things were getting better. She was feeling healthier, her baby was

okay, and she knew beyond all doubts, that there was nothing she would not do not to go through this again. About her husband, she dismissed him. She said, she knew exactly what he wanted. He wanted a son to prove his manhood, but as usual at her cost. She had decided that she now had two daughters, and that was enough. Her husband would have to choose whether he wanted to live with her or not. In fact, she continued, she wanted to be operated so that she could never have children again. All the women questioned her, asked her to think, even I did that. All of us who work at the centre were dazed to some extent, as she seemed to be spouting all the conceptualisations introduced in the last four-five meetings.

Finally, it was decided that she had every right to go for an abortion, but she should wait for a day or two, in which time, all the details of the clinic where she could go would be worked out. Our nurse found out, and without realising that she was putting herself into trouble, told Asma about the arrangements in front of her husband. Not only that... Asma's neighbour also wanted to have an abortion as she had a two month baby, and has TB, so she also planned to go quietly and have an abortion. Now everyone knew.

Asma's husband threw a fit, he almost hit the nurse, threatened to kill anyone who thought they would assist Asma, and asked the nurse to go away. She came running to me, frightened by the outburst. While we were deciding what to do, Asma strolled in, and comically, seemed to be comforting the nurse and me stating that we should not take her husband seriously, and that tomorrow she was ready to go the hospital. The next day, the other women at the pavement told us that Asma had a fight with her husband, he had beaten her, and then she had asked him to get out and leave the hut...which he had. Asma came and was ready to go. She even had her little baby with her. The nurse and other staff wanted to wait

for a few days, worried that she would not be able to cope with her husband's fury, and not wanting to be part to a hasty act of bravado.

But there was no stopping Asma. She said if no one was ready to go with her, then she would go on her own. At last, she was escorted and she had her abortion, her tubectomy and she returned. Being Asma, she then proceeded to talk to all the people in the area about why she did this. We too were amazed at her capacity not only to talk so much, but on such tabooed subjects, and at the same time, gave her all the support she needed emotionally, which meant listening to her talk.

What had happened was that women who heard her talk, both down on the pavement and in the centre, were all secretly admiring her for being so gutsy, and when they saw that so many had felt like this, then they came out in the open. Women said that they did not like the concept of abortion, but then, they also felt that it was a possible action. **At that time, we introduced the concept of contraceptives,** and what they were, why, how and so on.

Within a month of Asma's abortion, about 10 women came quietly to seek copper T insertions, and many more for just advice. The fantastic thing about this process was that this whole topic came out into the open, and from there we were able to initiate several other topics. In the meanwhile, both men and women on the pavement slum gradually began to take Asma's side, and felt that her husband was in the wrong. Their attitudes were based both on their observations of how he had treated her, and also on the discussions she had conducted on the pavements. As a result, her husband who did not want to face the community hostility, and who was in any case ready to come back to her, returned. He went to the dramatic end of asking her if she wanted him to rub her back or press her legs! - A piece of news, Asma of course broadcasted to all the next day.

Asma contines to come to the meetings, her general relationship with her husband is the same, he comes and goes, but we have found, that we have changed our way of perceiving her. She is very much in control of her own life; in her own way, she has gradually begun to change many of her actions, she comes and consults the group whenever she needs help, she gets everyone exasperated with her attention seeking behaviour, but her presence is invaluable to the group. She is a constant reminder to us that knowledge is assimilated and utlised by different **people in different ways.** It serves no purpose to demand compliance of a particular kind, which will demand that a specific behaviour pattern must change in order to help us evaluate that we have succeeded in instituting change.

Conclusion

This entire presentation is based on the belief that most attempts in community organisations are sustained because they have elements of evaluation and learning, and are a simulation of the natural process of making decisions on the basis of what exists in the form of reality around us.

In a way we cannot wish away structures, and we cannot wish away the existence of the imbalance in power, access to knowledge and its usage. But we can definitely attempt, with caution, various means of reducing this gap. This reduction of gap would serve the purpose of not only gaining for the people the facilities that will improve the quality of their lives, but it will also attempt to acquaint the very same people with the method of its operation, its source of control, and prepare a way to gain greater hold over the direction it takes.

For instance, in our women's groups, we have identified with the help of the women, all the areas which they have to deal with in

their day to day lives. We have chosen to understand why/what/where/when/who etc. of the matter in order to develop the new foundation for the development of a knowledge base for people, whose existing body of knowledge is no longer meaningful. If the foundations of this framework are to become solid, then our reasoning is that we seek to evolve the methodology by turning to the people themselves, rather than a well researched methodology alone. This way, people would be able to examine the methods by which they had assimilated knowledge in the past, and start from that familiar ground and then gradually move to other forms of assimilating and synthesising knowledge.

The seeking of knowledge must begin with the immediate and most common aspects of one's life, and move in larger circles to more intangible aspects of our lives. The method in which this knowledge is identified, sought, transmitted, and evaluated for its utility, must also start in totally familiar modes, and move to unfamiliar ones. This process must capture the very pattern of existence in which people live and attempt to become assimilated as a part of it. There is the joy and triumph of discovery for each participant, even if it is a personal discovery of a fact others feel is old hat. It means that we discard the present race for being the **first,** take joy in the fact that to each this discovery means empowerment, an achievement which indicates greater control over one's environment.

Important Features

* Accepting the rationality of women's behaviour, without passing judgement on them, helped women to analyse their actions more rationally.

* Individual crisis or immediate concerns were used as a basis for collective exploration and learning.

* Formation of women's groups, and taking up a range of issues along with health, helped in supporting learning and new behaviours.

* Women became the focus of health information and not just mere consumers; they were encouraged to take responsibility for their own community.

* Visual methods of education and monitoring progress of children, through photographs, role-plays and charts, helped in the educational process.

* Leadership among women was encouraged and supported, but new knowledge in the hands of a few was seen as exploitative.

WOMEN'S ORGANISATION AND HEALTH

Context

Society for Rural Education and Development (SRED) is situated at Kallru, Perumuchi Village near Arkonam in North Arcot District of Tamil Nadu. In order to understand the character of the organisation, it is necessary to go briefly into the historical background of its formation. In 1974, six young graduates of village Harijan background came together in Chingleput district in order to try to organise Harijans which are 68% of the population in this part of Tamil Nadu. All of these young activists had a training in community organising and they were inspired by the theories and methods of Saul Alinsky, Paolo Freire and Mahatma Gandhi. The focus initially was on caste issues. By 1977, an association with 3000 Harijan members had been formed. At this point, it was decided to spread out into other districts and after assessment of what had been achieved and which problems needed to be solved, it was decided to work on class base and to try to organise landless labourers in the Agricultural Labourers Association (Vivasaya Cooligal Iyakkam) irrespective of caste. By 1981, fifteen well-trained animators were working full-time in five districts: North and South Arcot, Chingleput, Madurai and Chittoor. In each of these districts, the Agricultural Labourers Association had about 3000 members of different castes, though predominantly Harijans, women and men, though predominantly men.

SRED was formed in 1979 near Perumuchi, the native village of Ms.Burnad Fatima who had been part of the initial group of six social workers who had started off together in 1974.

Having experienced the change from a caste to a class approach, Ms. Fatima had also faced the additional difficulty of being the

only woman in a team of men and having encountered the difficulty of unionising women agricultural labourers. Her main objective in building up SRED was to enable women to fully participate in decision making and in the economic, social and political life of the village.

It was clear from the beginning that this was a tremendous uphill task since women not only suffered the double burden of agricultural work and housework, including childbearing and childrearing, but also were socially disabled by confinement to the house, total illiteracy, violence like rape and wife-beating and social ostracism (e.g. being considered impure during menses and after delivery, being subjected to severe food restrictions during pregnancy and generally 'naturally' excluded from village meetings to start with; if they were widowed, social ostracism would be even more general).

SRED today works in 50 villages of Arkonam and Thiruttann taluks; thirtyfive villages are 'consolidated' villages where cells of the Agricultural Labourers Union and the Rural Women's Liberation Movement Sanghams (founded in 1982) have been formed; 15 villages are 'new' villages in which work has only started recently. Women's Sanghams and Agricultural Labourers Union function largely independent of SRED. North Arcot, like Chingleput, is on the whole a very dry area depending on the monsoon which often fails. Irrigation is by wells and village tanks. As in many other parts of Tamil Nadu, the water table has been affected by spreading of bore wells. There are two crops, mainly rice, but also dry crops like ragi, maize and kambu (a millet - sorghum).

Women agricultural labourers have 120-180 days of employment per year, men up to 220 days. Agricultural wages are as low as Rs.6/-

for men and Rs.4/- for women. Supplementary income comes from wood cutting and selling, also from brickmaking. The land holding pattern is such that there are largely small holdings and only very few cases of land concentration. This of course confines the scope for wage struggles within narrow limits. It is obvious from this background that the people with whom SRED works live in abject poverty and struggle for their very survival.

Origins

As far as health work is concerned, SRED did not start off as a health orgaisation. However, poverty being so rampant, health is clearly an important problem. Thus, health work came in mainly as an **entry point for women's organisation**. It was integrated with other activities like self-employment schemes; mainly embroidery and tailoring to start with, then mat-weaving, weaving of towels and sarees, carpentry. Plans are in process to branch out into cycle and transistor repair. Dairy and poultry schemes have also been tried. In Arkonam, a special women's shop sells sarees and readymades.

Apart from such attempts of income generation, building up rural women's organisation was the main objective. The Rural Women's Organisation has again and again taken up rape cases, wife murder cases, wife beating cases, also issues like water supply and road building, accessability of the village talk to **all** (i.e. including Harijans and menstruating women) as well as health issues most of the time by putting organisational pressure to make defunct government services available to the people. Recently, a journal, Women's Voice (Mahalir Kural), has been launched to report on women's problems and the activities of Rural Women's Organisation. Again, the journal has a section on health, especially drawing attention to nattu vaittyam (indigenous herbal medicine). A drawback is that there are too many men on the editorial board because women lack training in journalism.

The need for sustained health work first became visible in 1979, when a widow approached the organisation in need of an abortion. Since she was ashamed to express her problem straight away, she shrouded it in flowery expressions commonly available in village Tamil for this kind of an occasion (I have "not taken bath" for two months, i.e. missed the menses). The two young health workers did not understand her and sent her away with some aspirin. A few days later, the village drums announced a death. The widow, in fear of ostracism, had committed suicide. This incident created the idea to intensify health work and to link it up with rehabilitation of widows who are generally considered to be inauspicious and a social liability. A full-time health worker trained in primary health, was appointed and she took responsibility for training mainly middle-aged and elderly women in primary health, among these a number of widows and village dais.

Health Programme

The basic concept in the health programme is to **equip the women activists to be barefoot doctors**, to have a basic understanding of common illnesses and treatments and to make them conscious of improving nutritional standards even under pressures of abject poverty. The work thus covers various aspects: making government services available and enabling people to use them, teaching simple nutrition by locally available means (e.g. use of kirai, i.e. green leaves, papaya, pulses, preparation of "kirai coffee" and "low cost Horlicks"), teaching basic hygiene (like covering food, straining or boiling of water, keeping cattle sheds clean, prevention of water stagnation), **synthesing people's knowledge** of home remedies and herbal medicines, testing it, systematising it and passing it on, explanation of birth control methods and basic care as well as safe delivery.

From the original 35 villages covered by SRED work, thirty women were drawn to get training as barefoot doctors. Since they are nearly all illiterate, the training went on for three to four years. In a way, this is a life-long effort, since most women due to their illiteracy cannot take notes. Charts and flash cards are essential. Out of the initial thirty women, thirteen did not carry on consistently and more or less dropped out, while seventeen continued their training and work as birth attendants, having received a modernised version of the delivery kit with scissors, rubber sheet, etc. The basic training was carried on over two years and more, two full days per month. From the fifteen new villages, nine workers have been chosen by the women's sanghams who are at present receiving training. Health education is also a normal part of sangham activities and at meetings of the Agricultural Labourers Association, mostly in the form of health talks but also as skits and songs.

There are hardly any institutionalised health services provided by SRED. The community centre at Ulliambakkam runs a primary health clinic providing allopathic as well as nattu vaittyam services for common illness. Once in a week, a private allopathic doctor comes on part time basis for consultation in more serious cases. At Kaverirajapuram, a cobblers' village, once in a week, a health clinic is held under a tree with a homoeopathy doctor who comes on part time basis. In Konalm centre, clinic work was started but had to be abandoned because of transport problems (it is inaccessible by public transport). At Nuecai, a clinic was started with a gynaecologist, but this too had to be abandoned because of transport problems.

There are now eleven girls at the Kallaru centre who are working in self-employment schemes. Six of them also do part time health work. Three women full-timers of SRED are appointed for training work in primary health. SRED has altogether eleven full-timers

now, seven men and four women. Even the men animators who mainly work with the union and do work with men and women there, get all the primary health education with a special emphasis on women's problems.

With the participatory research into women's organisation and primary health, a new phase started because this provided an opportunity to take stock of the health activities, to review them and to change existing methods. This process of evaluation is certainly an open and ongoing one.

The Learning Process

Since the overall learning processes of SRED and the Rural Women's Liberation Movement came under review during this documentation of their health education work, it may be useful to describe this process.

Initial Meeting

We started off with a two-day meeting in September 1984 at Uliambakkam near Arkonam. The first day was spent trying to explain what the documentation process was about and sharing the experiences of eight animators. Initial discussions circled around questions like:

1. What are the most common illnesses ?

2. How frequent are deaths in childbirth and child mortality ?

3. How frequent are abortions ?

4. Are government health facilities available and are they used by the people ? Why ? / Why not ?

5. What is the SRED approach towards health work ?

It turned out that all of these questions can only be answered within the overall context of abject poverty of the people in this area. Most common illnesses like diarrhoea, dysentery, fevers, breathing problems have all to do with general malnutrition, lack of water and basic hygiene and the constant worries of survival. Apart from this, some ailments were identified as occupational or environmental, e.g. there was widespread tuberculosis, probably with underlying Byssinosis, among the workers of a cotton mill and there was a village where people suffered from water-induced paralysis. While death in childbirth is not a very frequent occurrence now-a-days (partly because of the thorough retraining of village dais), child mortality remans high, especially among girls. Abortions were obviously widespread and a follow-up on this question showed that they are more rampant than assumed.

While government services are available in a number of places, they are often defunct and in many cases people also do not have the money for the bus to go to the next health centre.

This overall situation accounts for some of basic priorities in the health work which were pointed out: To strengthen self-reliance by teaching cheap basic nutrition and herbal medicine; to help to make existing government services available; to propagate family planning.

It was then decided to proceed with the process in the following manner:

1. To document experiences where people had organised in order to make government health services available to them.

2. To document the use of herbs, home remedies, indigenous medicines (nattu vaittyam) and to record the positive and

negative experiences with such methods; also to document positive and negative experiences with allopathy in comparison.

3. To go more specifically into the question of women and health -- how do women understand their own bodies ? What is their understanding of the reproductive cycle, of birth control etc.? Are information and contraceptives available? What are the social taboos ?

4. In which sense is the health work an entry point for other women's work ? How does it relate to the other work and to the process of getting organised ? Why does this work pick up in some places and not in others ?

5. What are the most important aspects of the women's work to the women themselves ? Why do they feel it is an advantage to get organised ? What are their difficulties in getting organised ?

Larger Meeting

On the second day, a larger meeting took place with about 30 women, mainly members of the women sanghams, from different villages. Again, the process of participatory research was explained, the overall questions raised and since the women were quite enthusiastic to go ahead with this work, a plan was made about it. It was felt that in order to come to grips with questions 2-5 above, it would be necessary to have extended discussions and one way to generate them would be to conduct health festivals in different villages with exhibitions, skits, songs and pattimantrams (debate). Apart from the festival itself, the collective process of preparing it would give a lot of opportunities for exchange and clarification.

Already at this stage it became visible that there are indeed very strong social barriers against women taking control over their own bodies. These barriers get reinforced by a very negative attitude towards family planning, partly because of poverty. One cannot be sure how many children survive, partly because family planning is seen as something imposed from the outside. It turned out that many of the village dais who knew everything about delivery, have a very rudimentary understanding of the reproductive cycle. Many women said they did not know about birth control methods. Some had used abstinence in order to space births.

The women expressed that the **health work helped them a lot to build women's sanghams** and most sangham members have an acute awareness of health and nutrition, so much so, that many sangham leaders become freelance barefoot doctors and health workers. They felt that they learned a lot in the process and derived self respect from this. At the same time their competence about nutrition and simple illnesses also had increased their awareness of health as a business, the profits of the drug industries. Ironically, it seemed often to be the abject poverty which turned out to be a learning aid here. Since expensive nutritional supplements and sophisticated medical services were out of reach anyway, the "do it yourself" approach looked like the only viable option. Experience told that among slightly more affluent families, the drive for self-reliance would be less and the influence of advertising and impact of a consumerist allopathic approach to health more. It was also felt that the health topic needed to be discussed more in the agricultural labourers' union and that building a new health system needs to be a part of the overall transformation of society. However, there was obvious difficulty to spell this out. It was decided to have intensive discussions on health among strategic groups like:

a) SRED animators and agricultural union leaders
b) among the 17 "old" health workers
c) among the new trainee health workers
d) among the women trainees in the self-employment unit
e) among the women sangham leaders.

It was also decided to take the following concrete steps :

1. Recording struggles for availability of government health services and impact of these struggles on SRED health work.

2. Preparing health festivals in various villages, record the discussions, plays, songs, skits etc. used.

3. Make use of nattu vaittyam and nutritional supplements available in writing, record positive and negative experiences.

4. Have discussions in the women's sanghams on how health work relates to other women's work and to overall transformation of society. How can other forces of transformation be identified or built (e.g People's Science Movement, Ecological Movement, etc.) ?

Documentation Process

During the following six months, a substantial part of the above plans was put into practice. The health discussions with strategic groups took place, a number of health festivals were held in different villages and documentation on nattu vaittyam and on struggles making government services available was carried out. The activists put all these experiences into writing (in Tamil). Since a planned interim visit at that stage did not materialise because of practical difficulties, it became

necessary to evaluate these reports in writing and to crystalize the questions emerging from them in such a way that the further work could be planned in this light. Though the lack of contact at this point was a drawback, it later turned out to have its own advantages because it forced everybody to wrestle with the problems at sufficient depth to put things into writing. Due to this, the feed-back report sent back to the animators initiated a series of discussions among them and also partly in women's sanghams, which deepened the understanding of the work and gave it a new turn.

There was **first of all a methodological problem** which had to be faced. The reports of the activists were more in the nature of the usual project-work reports. The primary experiences of the village women hardly found any expression in them. So the question how to get access to the women's experiences raised the overall question of how participatory the whole learning process had succeeded to be.

The second fundamental question which arose was to which extent there was **inherent contradiction in the whole educational process itself**, i.e., to which extent the actual way of conducting an action or a programme was in contradiction with the professed objectives it tried to achieve. As it turned out, such contradictions mainly grew out of the fact that the broad and rather radical objectives were sometimes pursued with methods which were rather narrow and conventional. Both problems, the difficulty to find a participatory methodology and the inherent contradiction between ends and means can be made visible with respect to the different aspects of work which were reviewed.

Interventions to make government services available.

There was one report on how SRED made interventions in the acute health situation in different villages from April 1980 till

January 1985. The report lists thirteen such interventions. I am just quoting one such example in order to illustrate the nature of the intervention and the way in which it has been reported.

'Palliankupam 16.4.1980'

In Arkonam taluk, at Palliankupam village, seven families were affected by virus fever which has the danger of infecting others. No health personnel from primary health centres took care of the patients and therefore social workers and the public jointly presented a petition to the medical officers. A medical officer replied to the petition that there was no petrol in his scooter and so he could not visit the village. Later, petitions were sent to District Health Officials. Later district health personnel came to the village and took necessary steps. They gave injections and medicines to the patients and later the places where water had stagnated, were cleaned up.

This pattern is fairly representative of the procedure. A health problem is left unattended, telegrams are sent or a petition is handed over, and thus, health services are being made available. The illness range from fever in children, malaria, chicken pox, dysentery and tuberculosis. The action taken has three different aspects: (1) relief in distress, (2) teaching people how to deal with officials (e.g. writing petitions) and (3) teaching preventive health measures (e.g. hygiene, filling up pools of stagnant water with sand, etc.).

Two questions arose from this kind of intervention. Firstly, is it really the people themselves who learn to interact with health personnel and government officials or do the SRED activists step in as intermediaries? Secondly, is it really always so useful to make existing health services available? How does this policy

relate to the overall policy of SRED to make people self-reliant in matters of health and to develop their own competence about diagnosis and treatment of illnesses with the help of village health workers? For example, the curative efficacy of injections for viral fever is indeed very questionable. Of course, the people want an "oosy" (an injection) and the existing allopathic system does cater to such demands. But is not the SRED health education directed against a blind faith in the allopathic system which at times borders on superstition? Another example: health workers gave injections during an epidemic of chicken pox. There is no vaccine against chicken pox, so they could only have given smallpox vaccine, while smallpox is said to be eradicated according to WHO.

These questions raised triggered off a number of discussions on how to deepen the health education. Obviously, it is necessary to come to grips with very different concepts of health in one and the same person. There are entrenched convictions about diet, during illness and pregnancy, the quality of different foods as "hot" and "cool", about water intake and the use of home remedies. At the same time, advertisements and the claim that allopathy is "the only scientific medical system" make their own impact. Besides, exposure to methods of "nattu vaittyam" demands quite a different kind of involvement in one's own health situation (like growing herbs, preparing one's own medicines, etc.). While the attitude towards allopathy is usually a very consumerist and commercialised one, the traditional feelings about foods and diet are still operative at the subconscious level. The question arises whether the use of "nattu vaittyam" and allopathy can really go side by side and if so, how the use of allopathy can be made less superficial and consumerist. There is a need to build up an attitude in people by which they are able to understand health as a basic human right and not as a consumer good which is available for those who can afford it. It should

also not be seen as a charity dispensed by governmental or social service agencies. One of the main difficulties consists of developing a minimum expertise in people to recognise symptoms, the boldness to inquire about the diagnosis and the effects and side effects of medicines, the dangers of overdrugging and the use of compound drugs.

Many doctors admit that they over-drug because "that's what people expect of them." So there is a vicious circle to be broken: doctors prescribe because people "expect" it and people "expect" it because only a doctor who prescribes many medicines is seen as a concerned doctor. They feel to be taken seriously only on grounds of quantity. This of course only serves the drug industries and people need to understand what is happening to one's body, not to be simply made an object. This is particularly difficult since most of the women's sangham leaders and village dais are illiterate. While written educational materials are of help in training young girls who have studied several standards or up to SSLC, the training of illiterate women has to be much more in skits and role plays. While it is comparatively easy to put a delivery into a role play, it is much more complicated to come to terms with the use of existing government health services in role plays.

Health Festivals

In the course of the follow-up work on this documentation, various health festivals were held in different villages in order to provide opportunity to discuss health problems on a wider scale. The reports narrate a wide range of activities, like talks on eradication of common diseases by measures of hygiene "pathimantram" (competitive discourse on two different points of view) about the use of allopathic medicines and of herbal

medicines, songs on nutrition (e.g. the use of keerai - green leafy vegetables), demonstration of alternative food preparation (e.g. keerai coffee, low-cost "Horlicks"), nutrition in general, use of contraceptives, nutrition during pregnacy, delivery, skits about superstitious beliefs as causes of disease which are then set right with the help of a health worker, skits about poverty as a cause of disease, etc.

From the reports one gets the impression that a lot of effort has gone into these health festivals. Some of the work was done together with RUHSA, a professional voluntary health service which works in an area not very far away. The festivals were attended by several hundred villagers. There is no doubt that a lot of information was being channellised by such means and that there was a certain propagandistic impact. It is, however, not clear how village people relate to the information which is provided and to which extent they feel it is applicable to their own lives

There was a public discussion ("pattimantram") between two animators, the one advocating allopathic medicine and the other propagating herbal medicine. The argument for allopathy was based on the assumption that it is a more "enlightened" method and that the main problem consists of making drugs and health services available. It was pointed out that there is no method to prevent TB in herbal medicine while allopathy has vaccination etc. The argument for native medicine was also based on the insight that allopathy is not available to most people anyway, but the line of argument was one of self-help with such means as are available at the village level. The discussion was decided by a judge, another animator of the team, who decided that the argument for native medicine had been more consistently developed.

The problem with this method again seems to be that, while the people's situation and needs were very much present as an object of discussion their own experiences with either method, be it allopathic or native, are nowhere in the picture. It had been decided in the first meeting to document people's experiences with both methods and to pinpoint success and limitations in both (as related to the nature of illness, the availability of treatment, the trouble and expenses involved in getting it, the effects and side effects etc.). Without such documentation of people's experiences, the argument has a tendency to remain academic or propagandistic.

Another propagandistic effort which is being made is continuous exortation towards family planning, be it by temporary method or by operation. The methods of propaganda here are largely identical with those used by the government, the only decisive difference being that the health animators do not have their job security tied to the implementation of targets. Here again, people's experiences come in no way into the pictures. The assumption is that they can be happy only with a small family, that they are ignorant of family planning methods and will happily apply them once they get the information. The implications of this assumption needs to be discussed in great detail.

Health Education : Our Bodies Ourselves

A series of health education meetings were held with different types of people -- the girls who learn tailoring in the Kallaru Centre, social workers, nurses, village dais, women who belong to the women's organisation. Apart from general health topics like hygiene, use of native medicine etc., special emphasis was laid in these meetings to build up knowledge about the functioning of the reproductive system and to build up a

different attitude among women towards their own bodies. This is no doubt an extremely difficult task, since everything related to menstruation, sex, childbearing and childbirth is usually highly tabooed and it definitely belongs to the upbringing of a "good girl" not to mention about "these things" and to avoid to know them. The general pattern is that "men are supposed to know" while women are best kept in ignorance. The underlying social assumption is that a girl who has any sexual experience has "been spoilt". However, the suggestion is that to talk about the female body, sex and procreation has the odium of the scandalous. It therefore requires a great amount of courage to do this kind of work. There is also a question of use of language involved, -- does one simply take over this vocabulary of a girl "being spoilt" or is it possible to work with a different language which sets different social values.

It is also difficult to evolve methods which allow women to open up. One method is sharing about personal problems in small groups of two and three. Another method is to talk about all parts of the human body and their functions in order to build an awareness that sexual and reproductive functions are as natural as any other function of the body. Besides, slide shows were used about the reproductive system. On delivery, role plays had also been used.

There are different kinds of barriers to be overcome in different categories of participants in this kind of a programme. Among young participants, most of whom will be unmarried, there is a general embarrassment which has to be dealt with -- giggling, and a certain reluctance to face realities. Among village dais and more elderly women from the women's sangham, there is greater sobriety in facing reality and drawing on one's own experience but the actual level of information is very low.

In a meeting with young girls in which I participanted, the embarrassment was such that participants closed all the windows while the slide show was going on so that nobody would be able to overhear what was discussed and the showing of slides was accompanied by exclamations and giggles. While the girls expressed afterwards that they found it useful to know all these facts, the question arise how they can be dealt with in real life since the actual taboo of knowing is so great that admitting to know easily leads to accusations. One would have to explore to which extent the girls find it feasible to have access to means of birth control, what are their preferences, how do they manage to practice their knowledge in their own lives and how do they manage to communicate it to others.

In another meeting with elderly women (village dais and women's sangham leaders), it turned out that though the women had experience and understanding about childbearing and delivery, many of them did not know about methods of birth control. Some of them had used abstinence in order to space child births. Some had abortions. Some had reservations because they found it risky to go in for permanent methods because of child mortality. The tendency in the discussions was to place before the women the options of birth control (loop and copper T, operation, etc.) in such a way that they appeared as the scientific way to go about things while abstinence from intercourse was looked at as unscientific and unnecessary infringement on the marital rights of the husband which would create tension and misunderstanding.

It was felt that it would be necessary to go into this problem in greater depth. While the overall attempt of the health education is to give women more control over their own bodies and over their own lives, the question is how this can be achieved and whether it is achieved with the kind of family planning propaganda which was adopted initially. There was a tendency to depict operation as a

very good method because it has little side effect and solves the problem once and for all. Apart from the fact that tubectomy is quite a major operation for a woman, the very real problem of child mortality remains unresolved and the social problem needs to be discussed more deeply. If a woman is sterilized, there is male scope to suspect her fidelity afterwards. The other problem is that in case of operation either in the man or the woman, the effect can often be that the woman has less control over the frequency of sexual intercourse since "nothing can happen" anyway and the man will assert his "right" over her body more easily since no risk of creating futher offspring is involved. The "harmony model" applied by the animators which suggests that it is quite unnecessary and unscientific to deny a man intercourse in order to space births, does not take into account that abstinence may be a simple way of ascertaining sovereignty over one's body while all the nice scientific technical methods may in fact contribute to deny a woman control over her sexuality.

It therefore became necessary to explore how the feminist effort to give a woman control over her own sexuality, fertility and labour, relates to the fairly technical approach in propagating different family planning methods, preferably operation, much along government lines.

There is great need to go deeper into people's actual life experiences and to move away from the propagandistic level. Another important question which was raised in the first round of inquiry and which had not been answered was the question why there is such high incidence of abortions in the area. Why should women prefer medical termination of pregnancy to preventive measures if the latter are cheaper and less injurious to health ? It was felt that unless this question could be answered, it would be impossible to develop a proper understanding of the functioning of the family planning programme.

Documentation on Herbal Medicine

During the intermediate evaluation phase, a detailed documentation on the use of "nattu vaittyam" was made available (i.e. use of herbs and preparation of home remedies). To make these materials available in Tamil and English will in itself be extremely useful. It was however felt that the actual use of these remedies should be documented more, scope and limitations with this approach should be gone into and how it compares with the use of allopathy.

Rethinking

After initial documentation, a more conscious effort was made to come to terms with people's actual experiences and to assess the practicality of the health education imparted. The discovery of contradictions in the work led to a classification of objectives and to a brainstorming on how to evolve methods which would really serve these objectives.

Hygiene

One of the questions which were looked into in terms of practicality was the question of personal hygiene. While certain general rules like tethering cattle or covering food can be easily followed, it turned out that women do not really have basic access to hygiene. On the question when they take bath, the usual answer is "on Friday". Friday is the day when they take bath, put turmeric, flowers and clean clothes and go to the temple. The men, on the other hand, have a daily bath. The problem is not scarcity of water because women may be handling water all the time, washing clothes, scrubbing vessels, watering plants. The problem is one of division of labour and length of the working day. Women simply do not find the time to take bath. Bath is a

luxury reserved for men. Indeed, detailed inquiries into the working day of women and men among landless agricultural labourers have shown that women work up to six hours more every day.

Another problem is the lack of privacy. It is more difficult for women to take bath because women have to be constantly careful not to expose themselves to other men's eyes. This problem also affects their toilet habits. Women go to the fields very early in the morning or late in the evening. The contradiction is that it should be dark in order to be less exposed, on the other hand, it is more dangerous to go out in the dark because of the danger of assault. All this leads to constipation and strain on the bladder. The problem gets aggravated during menstruation and pregnancy.

These conditions are so much taken for granted that it is difficult to discuss them at all. It is also hard to think of any alternatives. Common toilets in the villages ("MGR toilets" a government programme) never work for lack of maintenance. One also wonders whether it is feasible to have public toilets for women and men in one cubicle just separated by a wall and with different entrances. If the toilets for women were in one locality and those for men in another, it might work better. Private toilets are entirely absent because of the needed investment, water problem and the fear of bad smell close to the living place. An experiment with a Gandhian dry toilet by two health workers was also given up. So at the moment, it is very unclear in which direction to go. However, by being able to slowly talk about the problem it becomes more clear that the situation is quite unbearable and thus the motivation to tackle it slowly grows.

There is also the question of how to deal with menstruation. Women use old rags for sanitary towels and it should be explored whether it could become an avenue of self-employment to produce cheap sanitary towels at the sewing centre in Kallaru. It was also observed that bathing places for women have vanished over the last ten years due to environmental factors. Generally, the water level in the area has gone dry and others have been reclaimed for agriculture. Even where they still exist, the men are washing lorries in them. So the old custom of women to go to the village tank and bathe, wash clothes and chat with each other has been abandoned. This not only undermines cleanliness but also women's solidarity. The question came up whether the women's organisation can try to create a new place for women where they can wash, bathe, chat and spend some time together.

Abortion

It transpired in the course of time that abortion is a much more gigantic problem than was evident from the beginning. While the women who had been in touch with the women's sanghams and with the health programmes had picked up a general knowledge of contraceptives, it became clearer that the most prevalent forms of limiting the size of family were actually abortion and to a certain extent infanticide (especially of girls). In a discussion with middle aged and elderly village women it turned out the nearly each of them had experience with abortion, either undergoing them or performing them or both. Abortion is virtualy a cottage industry. It is usually carried out with home remedies as eating green papaya, swallowing large quantities of camphor and turmeric. The most widespread and most dangerous method seems to be the use of "yerkan chedi" (a plant the white flowers of which are offered at Ganesh chathurthi). A dried yellow leaf of the plant is taken and the stick in the middle of the leaf is taken out and shoved up the birth channel into the uterus. This

procedure causes infection and ferocious bleeding and may lead to severe pus formation and even blood poisoning and death. All the same, the method is widespread since it is free of cost and very "reliable" in the sense that the foetus does not survive. Whether the woman does remains to be seen. Often women have to go in for medical treatment in order to survive.

As far as infanticide is concerned, it remains a pious wish to say that girl babies should be treated equal with boy babies. As long as the whole status of women in society is as it is, it remains idealistic to demand equal investment of energy and money in girls as in boys. Girls are still a liability. They will cost a dowry, they earn less wages, they will be given away to another family and are therefore not allowed to support their parents. On the contrary, they will need support again during pregnancy and delivery.

While women agree theoretically that girls should be given a chance and treated well, the problem is to create a social set-up in which girls do not need to marry or give dowry, if they choose so, where they have work with equal pay and where they are free to support their parents. A substantial part of the problem of child mortality is in fact the problem of the morbidity of the social system of patriarchy. At the present moment, it is not yet visible how the women can go beyond discussions towards concrete solutions. The sobriety with which some of them admit infanticide is breathtaking and hear-trending. It was discussed how to take this problem up in dramas and also how to pursue the GOBI programme for children (Growth, Oral rehydration, Breastfeeding and Immunisation) within the overall framework of fighting discrimination against female babies.

Birth Control

The facts of abortion and infanticide again raised the question why family planning is used only by a few. It was recognised in the course of the discussions that "family planning" as such is often resented as a form of government interference in family affairs. It is therefore much more meaningful to discuss the problem as birth control in the overall context of allowing women control over their bodies and over their health.

The unpopularity of sterilisations as a method of birth control is based on two factors :

i) People shun irreversible methods because of child mortality, and

ii) Socio-cultural barriers.

Men think they lose their "virility" when they get sterilised. They think they will be "weak and unable to work sufficiently to support the family." If the operation fails and a woman gets pregnant, she will be punished for infidelity. If a women gets operated, her fidelity will be eternally suspected. Women often feel they will be subjected to sex even more indiscriminately once operated than otherwise. There is also a feeling that a woman who has lost her fertility for good is treated with less respect. The problem seems to be that such "loss of respect' does not get compensated by a feeling of having gained control over one's own body because control over sexuality remains entirely with the man and may in fact be more than before. Thus, to get away from the abortions can only be achieved by means which would in fact enhance a woman's control over her own body.

Contraception looks like an obvious way to do this but it suffers again from at least three identifiable drawbacks :

a) Socio-cultural : There is a tendency among men to refuse to use Nirodh because they say, it deprives them of "full satisfaction". This point will be analysed in greater detail below. Women, on the other hand, suffer again suspicions on their fidelity if they use contraceptives.

b) Technical : There remains also the problem of the choice of contraceptives. Barrier methods which have least side effects, are not practical in the village context because they have to be applied directly before intercourse and with the frequency and abruptness of intercourse, the lack of privacy and water facility and lack of place to put things outside the reach of children, insects, rats etc., they are not feasible.

Pills have the drawback of requiring utmost regularity. Besides, they do entail side-effects like headache, giddiness, pain in the breasts, etc. Intrauterine devices are difficult for agricultural labourers because they have to be put by medical personnel. They do get expelled by some women and also cause backaches and irregular bleedings. Injectable contraceptives have appeared through some private doctors but since the possibility that they may be cancer-causing cannot be ruled out, SRED hesitates to recommend them.

c) The thinking process itself: There seems to be an overriding difficulty about contraceptives. Through the educational processes of SRED, women have got a general understanding of the reproductive cycle and of the possible choices to interfere with it, it seems that the knowledge remains somewhat abstract. This may have to do with the fact that apart from the menstrual bloodflow which can be felt and seen, the overall process of ovulation, fertilization and

early pregnancy cannot actually be observed. To take the step of interfering with these invisible processes requires a higher level of abstraction than to go in for an abortion after having missed one's periods. This seems to be a matter of "cross the bridge when you reach it".

It was felt that concentrated work needs to be done on the underlying socio-cultural assumptions about "satisfaction" and "infidelity" etc. and that the actual understanding of the reproductive cycle has to be deepened andinternalised to such an extent that interference with it becomes a really feasible choice. It was felt that instead of propagating the two children norm and then recommending sterilisation it would be much more adequate to the living situation of the women to work towards spacing of births. This can however only be achieved if the total sexual control of men over women's body is broken down.

A New Type of Health Exhibition

In the course of these deliberations, a new type of health exhibition was developed. A series of 45 posters was made (basically using VHAI slides and Our Bodies Ourselves as models) entirely on the reproductive cycle, the sexual and reproductive organs, ovulation, fertilisation, pregnancies, the birthing process, cancer detection, sterilisation etc.

This exhibition has advantages over slides in that it can be used witthout electricity and that women can look at it at their own pace. It is very important to be able to dwell on the problem at length because the actual embarrassment of facing one's insides in this way is beyond all measure. Women admitted again and again to having been shocked at what they saw but they also expressed surprise, joy and pride. Even the health worker who explained the posters had to fight with her embarrassment and had a tendency to

rattle down the information in great haste. It was later decided to avoid this and to first give the women a chance to read and to ask questions. One old women objected violently: If women know all this in advance, how will they ever have the courage to get married at all. But young women counter-argued that this would support them to be less ignorant and helpless than before.

The exhibition was first shown in Ulliambakkam to about 50 women of different ages who had come from surrounding as well as far away villages. They all were sangham members. It was later shown to the girls in the Kallaru centre who are in the self-employment training and partly in health training. When we discussed the exhibition in these different collectives, we discovered some lacunae in it which were later overcome as a result of these discussions. The 45 posters only dealt with the female body exclusively. It did show tubectomy but not vasectomy.

This had been done so out of a feminist motivation to come to terms with "our bodies ourselves". However, it was felt that this approach was not true to reality. The male contribution to pregnancy became visible only in the form of a few sperms, the most expressive poster of this kind being that of a giant sperm wriggling its way towards the egg ("pambu pole" - "like a snake", as the women said). It was felt that there is surely more to getting pregnant than just that. Why did it seem to be difficult to face and depict this "move"? One underlying problem seems to be the sheer habit of exhibiting, exposing and even disssecting a woman's body without much problems, quite in contrast to the actually imposed "modesty" and "shyness" of women. On the other hand, while men uninhibitedly and even shamelessly expose themselves, including their private parts in public while they relieve themselves, there is much more of a taboo to actually depict a man's body, leave alone his genitals on a poster. This is one reason why we feel so free to dissect a woman's genitals and

reproductive while we find it difficult to look at a man's penis and testicles with the same kind of detachment. It was, therefore, felt necessary to depict the man's reproductive system as well and to admit the involvement of the penis in intercourse. It slowly surfaced that there is a need to understand in greter depth the relationship between sexuality and fertility in order to come to terms with the overall problem of birth control and control over a woman's body.

The difficulty to do this can be easily illustrated by the fact that one of the great revelations to women is the news that they actually have "three holes", urinary outlet, vagina and anus. Virtually none of the women was aware of this before marriage since there is total taboo on talking about one's body. One young girl said she thought for a long time that talking to a man and laughing could make a girl pregnant since this was what her parents forbade her to do. Even when giving birth the first time, some women are still confused from where the child actually comes out. In the posters, the female genital organs were entirely depicted from the point of view of fertility. The fact that women have a sexual organ of their own in the form of the clitoris which is not related to fertility was felt to be too much of a shock to be disclosed at this stage. The female body is seen entirely in terms of fertility, even as far as women's own subjectivity is concerned. Women may be "made sex objects" but the question how they could possibly be subject of their sexuality and perhaps enjoy it, is kept out completely. Even women's protest against making women sex objects is often carried out by mobilising values of motherhood and nurturing. Women as sovereign sexual beings seem to be unthinkable to women and men alike. However, this is not just a question of a woman's general quality of life, it has quite devastating medical implications and at times becomes a question of life and death.

Men, on the other hand, are primarily seen in terms of sexuality, they are first of all sexual beings. The fact that their orgasm is achieved by ejaculation of sperm which makes a women pregnant (while a woman's orgasm is entirely independent of fertility) is generally neglected. Since it is the women who gets pregnant, fertility is "her" problem. But in fact "her" problem is that sexual satisfaction **in the man** is related to fertility. Precisely this is her actual health hazard. It was, therefore, felt that an exhibition on the reproductive cycle needs to depict these facts of life in a truthful manner.

Relationship Vs. Facility

These discoveries led to deeper discussions on sexuality and fertility and on the actually existing patriarchal system of the family. It came out that women, while they see themselves as childbearers and as beasts of burden, most of the time experience sex as one more household chore like fetching water and firewood, cooking and serving food, finally surrendering their own body. These discussions were very interesting because the women felt finally free to speak out in a large group while at the same time a few of the men animators were also present so that there was a certain amount of interaction between women and men as well. Since men are seen as primarily sexual beings, the assumption seems to be that sex is their birthright and their supreme need, their "full satisfaction" an ultimate goal to which all other considerations have to be subordinated (e.g. refusal to use condoms. In a big meeting with fifty women only two said their husbands used them.) On the other hand, the sexual satisfaction of the woman does not come into the picture. Since the men enjoy sex, they presuppose that women also do. On the question whether they know what their women feel they said: How can we know, we have no words to talk about "such things". Men were completely taken aback when married young women said that they enjoyed caresses and tenderness while they often hated actual penetration.

Since "full satisfaction" of the man is the supreme value, the women needs to be ever ready. Women are often not allowed to go to night meetings or leave alone for seminars which last several days, because they will not be available at home. The women are also frightened that if they do not provide these constant services, the man may shift to another woman and ditch them. Even elderly women face the "problem" of daily intercourse.

This led to the characterisation of a man's attitude towards marriage as a "facility" (Tamil : vasathi). Men get married when their mothers get too old to cook for them and they expect from it all the services like cooking, washing, health care, childbearing and rearing, and sex. The one service they render in return is "protection" (pathukappu) which in fact only becomes necessary because of the general violence against women in society which makes marital rape preferable to the constant danger of indiscriminate sexual use, gang rape and the like.

Women, on the other hand, seem to constantly strive for relationship (Tamil : uravu), they are the ones who have to constantly compromise, patch up, restore, look after. If one tries to understand why this is so, the answer is probably that, since the overall relationship is experienced as enslavement (rendering services), building a human relationship is necessary to ameliorate the hardships of enslavement. Appealing to a human relationship may make patriarchy more bearable. The tragedy is that the men are quite unaware of the true character of the relationship. To them, like to any landlord, receiving services in good spirits already constitutes a relationship. Like the 'Jajman", the man is convinced that his subjects must love him since they render their services so untiringly and even appeal to his humanity.

While all this sounds rather too atrocious to be true, what compels me to write down all the same, is the pathetic bitterness which I have seen especially in the eyes of the old women after a life of toil. If they come to the women's meeting with enthusiasm it is because here they can speak out for the first time; and they feel they can take each other seriously in their own rights, and they always find something new to learn.

The one underlying accepted value which seems to be so extremely difficult to erode is the assumption that the man has the right over the woman's body "because he has tied the thali". Only one woman, a very courageous sangham leader of Ulliambakkan, insisted that "We must fight for the control over our own bodies", though we all know that she is as much beaten up at home as most of the other women.

It seems to be clear that unless women's right to control their own bodies becomes an accepted basic human right, the use of contraceptives remains a remote possibility and the woman may go on for a long time to undergo home-made abortions and allow their babies to die of neglect.

Woman's Control Over Her Own Body

In the workshop which accompanied the exhibition and which brought out most of the crucial insights which are summed up above, a lot of other information also came to light which, at a closer look, seems to be very much related to the social mechanisms which withhold from a woman's control over her own body. Even though the women are Dalits, they believe in seclusion during menstruation. They should not touch foodstuffs (especially pickles), should not go out, should not bathe and put flowers, etc. They experience themselves as impure and weak. They should not use disposable sanitary napkins because if some

animal eats these, this will cause the fertilised egg not to settle in the uterus or early miscarriage. If menstruation ceases in a woman due to anaemia (which does happen since anaemia is widespread), this is ascribed to a "spirit". It is also related to the goddess Katteri. When they are pregnant, women are more susceptible to be possessed by spirits. They are also not to cross rivers and should avoid to go into the sun. There are very comprehensive food taboos on pregnant women (on the list of foodstuffs to be avoided are : coconut, mango, papaya, jaggery, raw rice, grapes, bananas, jack-fruit, sweet potato, potato, maize, kambu (a millet-sorghumi), tinai (another millet) and a number of vegetables, including kirai and eggs). Women are even restricted in their water intake. One really wonders how they keep alive at all with a diet chiefly consisting of rice and virtually nothing else to go with it. The idea is that the placenta may grow too big or that the child wll be too big and delivery difficult.

Women are also kept in the dark about delivery. Since they are brought up in the belief that a spirit or a god leaves the child at the doorstep or that the old lady who sells vegetables has brought it along, they find it difficult to envisage the process of delivery even during first pregnancy. Some think the child may come out through vomitting from the mouth; others believe the belly may open underneath the navel. Some believe the child comes out from the rectum. Some believe that the child comes out piece by piece hand from hand, eye from eye and then gets assembled. Only three young girls had learned about pregnancy and delivery at school and one girl had got a rather realistic picture by overhearing other women talk about it. While exposures like the poster exhibition go a long way to set such beliefs right, a lot remains to be done to enable women to be in command of their bodies during delivery, by breathing exercises and methods of natural childbirth. It is quite a step ahead to recognise that

the pain during labour is due to contractions and that the most efficient way of dealing with it is not to clench ones fists and grind ones teeth while waiting for it to go over, but that there is an active way of combatting the pain by systematic breathing and relaxation. It is envisaged as a future step to go into methods of natural child birth more systematically. It also remains to be explored to which extent this process can be explained to men and whether men can be involved in deliveries in a supportive way.

It is also important to see these prevailing "superstitions" about women's bodies during menstruation and pregnancy in the overall perspective of violence against women and oppression through perpetuated ignorance. The tendency sometimes is to ridicule women for their ignorance and superstitions. However, many of these are just an expression of concretely experienced powerlessness and isolation. Nobody would nowadays easily come forward to blame a Dalit for his belief in untouchability. His mindset will be seen as the product of an oppressive system. Women's minds deserve to be understood in this overall framework as well.

Lessons Drawn

It is certainly not easy to draw clear-cut lessons from a learning process as complex as the above described. One definite result is that the documentation process itself has created more intense involvement and mass participation in the health education. Apart from this, following observations can be made.

1. Certain contradictions were discovered between different objectives within the health programme. The activity of making defunct government services available and then dispensing health services rather at random, was in

contradiction with the overall approach of using "nattu vaittyam" making people subjects in dealing with their bodies instead of making them objects and consumers of treatment.

2. Despite the contradiction mentioned above, there is no doubt that the experience of SRED in the use of "nattu vaittyam" has drawn widely on people's experiences and has contributed a lot to making people self-reliant in handling common illnesses.

3. Another contradiction which became visible was between organising women for greater economic and social self-reliance and pursuing a very technical, propagandistic approach towards family planning, much along the lines of government programmes. In the course of the research, this approach changed completely towards birth control in the context of establishing women's control over their own bodies and their own health.

4. During the change of approach, major changes in language became necessary. For example, today it will no longer be said that a girl "has been spoilt" if she has been sexually used. Also, the traditional word "Karpazhinppu" for rape (which means destruction of chastity) has been replaced by "balat karam" (sexual violence). While it may look surprising that all this should be part of a health programme, it touches deeply upon the underlying assumptions about and attitudes towards a woman's body.

5. It became increasingly clear that many health problems cannot be tackled without tackling the underlying social root causes. The prevalence of illicit abortion and occurrence of female infanticide cannot be tackled without

making the effort to break male sexual control over women's bodies and transforming social relations and production relations within the family. Even access to basic hygiene is dependent on this.

Important Features

* Health programme helped in building and strengthening women's organizations.

* An integration of health and women's issues was made within the "sanghams".

* Women's leadership was supported and strengthened through training in health.

* Women's knowledge and experiences were valued, articulated and systematized.

* Educational process was built on life experiences of women, and first dealt with misinformation women had about their own bodies and health.

* Men's education and information was seen as supportive activity.

* Women's participation in income-generating efforts became supportive of health programme.

* Women's control over their own bodies, within the larger social context, was seen as the long-term focus of health education.

HEALTH INSURANCE SCHEME

Genesis

Kasturba Hospital situated in Sewagram, a village near Wardha, Maharashtra was started by Mahatma Gandhi in 1945 in memory of his wife Kasturba. With 15 beds for women and children initially, it grew to have 50 beds and extended its services to men as well. After Gandhiji's assassination in January 1948, the management of the hospital was taken over by Gandhi Smarak Nidhi. The latter found the expenditure of the hospital to be very high and wanted to hand it over to the government. This was not agreed to by the workers who went around the neighbouring villages to consult the leaders of the village communities whom they had been serving earlier. The village leaders agreed with the workers and offered to make voluntary contributions towards the expenditure of the hospital. In some ways, this constituted the genesis of health insurance.

In 1964 the Kasturba Health Society was registered and the management of the hospital was passed on to it by the Gandhi Smarak Nidhi with an endowment of Rs.10 lakhs. The Kasturba Health Society was keen on extending a comprehensive health care package to the villagers that was inclusive of preventive, promotive and curative aspects. From this thinking evolved the concept of insuring a whole village. In each insured village, people could insure by paying Re.1/- per head per year for which they would be given a thorough check-up along with advice and help for promotion of health, prevention of disease as well as treatment in case of illness. The village panchayat could insure the village or the villagers could do it themselves. If 75% individuals were insured, the village was considered to be an insured village. Later on, health insurance was extended to individual families at the fixed contribution of Rs.15/- for the whole year.


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Gradually these charges were raised and are now Rs.35/- per annum for a family of five.

In 1969, Kasturba Hospital became a teaching hospital and the number of beds was increased to 500. When Mahatma Gandhi Institute of Medical Sciences (MGIMS) was started, the Health Insurance Scheme was extended to its faculty, staff and students. However, the challenge that confronted MGIMS was to find out ways whereby the Health Insurance Scheme that existed for the surrounding villages, could ensure that the villagers would ultimately start taking care of their own health care. It was in 1977 that new initiatives were taken in this direction by Dr. Ulhas Jajoo, a faculty member who joined the staff of MGIMS. Under his guidance and support, a new orientation was given to the health Insurance Scheme.

Reorientation

Imbued by Sarvodaya ideology, Jajoo became part of the Medico Friends' Circle, a study group that consisted of young doctors and students who were seriously concerned about the deteriorating health situation in the country. With growing realization that the health services were negligible in rural areas, the study group decided to move out and gain field experience. It was under these circumstances that Jajoo decided to join MGIMS. Its advantage was being based in a rural area with no other hospital in the vicinity, it was more accessible to surrounding villages. The management also subscribed to the thinking that MGIMS should cater to the health needs of the villages nearby. Jajoo's visits to other health projects in the country had shown him that the main reason for starting these projects was on compassionate grounds. The all enveloping love often created dependency among the beneficiaries. Moreover, these projects were so heavily financed that their replicability

was not possible. Jajoo realized the scope for investigating how health sciences could be extended to the rural poor without doling them out.

From the beginning Jajoo and his team of medical students believed that charitable services, given free, might earn goodwill but would increase dependency in the minds of the people. It was, therefore, decided not to make any monetary or material inputs but to utilise the existing and available resources.

As the group plunged itself into action, the members realised that being trained in the traditional western-oriented medical culture, they were unaware of the realities of the village situation. Consequently, they went through a series of experiences a few of which were successes and others were mostly failures.

After visiting different villages within a radius of about 10 Kms. around Sewagram hospital, the group narrowed down the choice to one village named Nagapur that was 6 kms. from Sewagram. In this initial phase, MGIMS was not involved institutionally; and as the involvement of the students was voluntary, the morale was very high.

The villagers of Nagapur welcomed the medical team and made a request to start a regular weekly clinic. The medical team had nothing to offer but their skills. Resources in the form of money for drugs, a place to run OPD, and assistance of a village health worker had to be raised from the community itself. The villagers decided to contribute Rs.4/- per family for the drug bank and to meet the other stipulated needs. The school building was provided for running the OPD.

The medical team realised that their experiences of running such an OPD were very different from what they were used to in

the hospital set up. "People expected prompt cure, asked for injections, and were more satified with costly drugs. As the drugs from OPD were sold at cost price, the poorer section of the community often approached only when the disease was advanced. They had a tendency to ask for free treatment. Some felt it was their right to get free drugs as they had contributed Rs.4/- towards the drug bank. Credit was kept pending. They did not hesitate to blame the medical team if the treatment given did not provide them prompt relief. The drug bank went bankrupt."

Acknowledging the failure of this system, a new strategy was thought of in order to get back the amount that was due. In a village meeting, the names of those against whom credit was pending were read out. This kind of public humiliation prompted some to clear their dues. Also in the same meeting it was decided to deny drug facility to defaulters and to impose penalty for delay.

A small incidence that occurred thereafter made the medical team realise that their strategy was wrong. One day a mother brought her sick child who was suffering from bronchopneumonia. The cost of the medicine prescribed was about Rs.15/-. The mother did not have enough money to pay the bill, and promised to pay within a week's time -- a promise she could not keep. In this particular case as in other deserving cases, the medical team advanced credit. But the decision to deny drug facility to defaulters and to impose penalty for delay resulted in providing medical services not to the poor and to those families in real need of medical aid, but to the better-off families only (see table - 1).

Table No. 1

Utilisation of Out-Patient Services in village clinic at NAGAPUR

Socio-economic Grade	Total population	Insured Population availing services	Village clinic attendance	Clinic attendance per insured
Farmers	398	250	434	1.74
Marginal Farmers & Wage earners	76	52	39	0.75
	474	302	473	

Renewed Efforts

So the medical team sat once again with the villagers to evaluate their services. The principle of each member of the community contributing to the insurance scheme according to his individual capacity, was accepted. That was the way in which they had contributed towards construction of a temple. There was general agreement that to be accessible to the poor, health services had to be free, at least for the acute unforeseen illnesses. "It was, therefore, decided to establish and administer a village fund for medical treatment, based on contributions in kind to be collected at harvest time. The contributions, it was agreed, should vary according to land ownership and wages. Farmers would

contribute 2 payali (a measure equivalent to 2.5 Kgs) of sorghum per acre and wage earners a flat rate of 4 payali, more. Any one who had additional sources of income would contribute 4 payali more. Non-contributors would be excluded from free treatment."

In the first year, the team succeeded in collecting contribution from 90% of the villagers. The funds were utilised for covering costs for the dispensary, electricity bills, examination table and some equipment for starting a library and a balwadi.

But the experience of the team the following year was very different. As they went at harvest time from house to house to collect the promised contribution, the most active and enthusiastic supporters of the village health insurance scheme were conspicuous by their absence. "During our second visit we experienced similar evasions or excuses. By the fourth visit it was obvious that the richer villagers had decided not to support the scheme." Even the data collected by the team (see table 2 below) showed that the contribution from the richer community members had dropped slowly over the years. On the other hand, the landless labourers as a group had increased their participation in the scheme. The net result was that the total collection fell short of the requirement for sustaining indoor hospital charges.

Table No. 2

NUMBER OF FAMILIES WHO CONTRIBUTED TOWARDS VILLAGE FUND BY DIFFERENT SOCIO-ECONOMIC GROUPS

Year	No. of families by Socio-economic Groups					Total collection (Jowar in Qtls.)
	1	2	3	4	5	
1978	16	15	17	7	5	13.9
1979	9	13	11	3	8	9.0
1980	8	11	10	5	10	8.5

Socio-economic Grades

1. Families who employ labourers on yearly contract (Saldar) for agricultural work.

2. Families who own irrigated land and a pair of bullocks, but do not employ Saldar.

3. Families who own unirrigated land and a pair of bullocks but do not employ Saldar.

4. Families who own land but neither employ Saldar nor have bullocks.

5. Landless labourers.

At the end of the 2nd year of work, an analysis of the dispensary data maintained by the team showed that 95% of the illnesses treated were in the category of self-limiting ailments that could be treated by a village health worker. These ailments were upper respiratory infection, viral fever, gastrointestinal infections etc. The remaining patients needed expensive medicines (mostly antibiotics) or hospitalisation. The team realised that a village dispensary needed to be linked to a Central hospital, to which patients with acute problems could be sent. The team therefore concluded that rural health services that catered to the needs of those who could not afford to pay **could not be totally selfreliant.**

New Directions

And so, from the 3rd year the village dispensary was linked with the Sewagram hospital for referral services and for free hospital admissions. But experience showed that there was a

tendency among some villagers to misutilize the free services of the hospital. Consequently, while acute and emergency cases were treated free, 25% of the hospital bill was charged for planned sickness, i.e. normal deliveries and chronic illnesses like cataract, hernia, polio etc. As a disciplinary action, non-insured in-patients were charged hospital bill lest they go back to village and discourage village folk from insuring themselves. It also served as a lesson for them to get insured in future. The village dispensary was now run by the village health worker (VHW). VHW was provided with a back-up support of a mobile health team once a month, consisting of a doctor and a nurse to provide maternal and child care services. Village contributions provided 86.7% of the money required to finance the village health worker, his drug kit, the ANM and fuel expenses for the mobile health team. The rural health service had cost the team as little as Rs.2 per head to run. If the hospital income from admitted patient is taken in account, apart from meeting the cost of providing door-step services, hospital could recover Rs.18.50 per indoor admission in the year 1983-84 (see Table 3).

TABLE NO. 3

COST ANALYSIS OF YEAR 1983-84

Total population covered (in twelve villages)	10,297
Total number of hospital admissions	425
INCOME	Rs.
Contribution towards health insurance	18526
Recovery from hospital admissions from	
- Non-insured patients	6774
- Insured patients (paying 25% of hospital bill for chronic-old illness)	3932
	29232
EXPENDITURE	
Honorarium for village health worker (35% of village contribution towards health insurances)	6484
Village drug kit (at Rs.30/- month)	4320
Fuel charges for the monthly visit of the mobile health them (at Rs.1/- Km. for an average run of 15 kms per villages)	
Salary of ANM (at Rs.700/- per month covering 12 villages)	8400
	21364
Balance remaining with the hospital	7864
Average subsidy to the hospital per admission (total of 425 admission)	18.5

Thus, the experiences in Nagapur became the learning ground for the group to design an appropriate health care strategy that would reach out to the poor. By raising resources locally, the poor contributed towards the health services according to their paying capacity and as a result, the health facilities became accessible to them.

On the basis of the lessons learnt from Nagapur, the team extended the health insurance scheme to other villages. In the 4th and 5th year of their work, based on an operational link between a village health worker and a mobile health team financed partly by village contributions made in kind, the insurance scheme was extended to fifteen villages. VHW facilitated timely referrals to the hospital. Table 4 below gives the yearly progress made, beginning from the year 1981.

TABLE NO. 4

TOTAL COVERAGE OF HEALTH INSURANCE

Year	Total No. of villages	Total population	Insurance coverage (%)
1980	1	485	64.3
1981	2	1197	43.5
1982	4	3924	46.5
1983	8	6950	50.5
1984	12	10105	53.7
1985	15	11377	60.43

Table 5 shows the response of different communities to the health insurance scheme from the first year of acceptance, irrespective of the year started, to the 5th year.

TABLE NO. 5

DIFFERENTIAL CONTRIBUTIONS

	Total Population	Socio-economic Grades I+II+III	Socio-economic Grades IV+V	Total insured
1st year	11,633	52.2%	57.6%	55.6%
2nd year	5,241	60.2%	69.8%	65.1%
3rd year	3,491	67.2%	63.1%	60.5%
4th year	3,111	43.7%	55.1%	50.7%
5th year	734	62.8%	81.5%	72.1%

One can see from table 5 that the participation of the poorer sections of the village (under column IV+V) in the health insurance scheme increases substantially after the experiences of the first year. In other words, the scheme becomes more acceptable to the poorer sections once they find it is accessible to them. The data available for one village (Mandaogarh) would elucidate this point (see table 6).

TABLE NO. 6

DIFFERENTIAL PARTICIPATION

	Total Population	Socio-Economic Grades I+II+III	Socio-Economic Grades IV+V	Total Insured
1981	707	38.4%	29.8%	34.3%
1982	727	55.7%	71.8%	64.0%
1983	753	71.0%	77.5%	73.8%
1984	731	59.1%	65.9%	62.3%
1985	-	62.8%	81.5%	72.0%

The hospital facility is also utilised more by the poorer strata as is obvious from table 7.

TABLE NO. 7

ACCESSIBILITY OF HOSPITAL FACILITIES BY SOCIO-ECONOMIC GRADES

Year	Population per hospital admission		Total Hospital admission
	Soc.Eco.Grade I+II	Soc.Eco.Grade III+IV+V	
1983			
Insured	8	10.3	360
Non-insured	31.3	24.2	134
1984			
Insured	10.4	11.73	475
Non-insured	29.5	18.77	221

On the other hand, in two villages, the experience was that the participation of the poorer sections did not go up substantially. Consequently, it was decided to discontinue the health insurance scheme in these two villages for lack of adequate participation and even enthusiasm among the poorer sections.

One of the principal factors for the low participation of the poorer sections has been attributed to the poor performance of the village health worker who can make the hospital facilities accessible to the poor. The conflict of interest of the middle/uppper class vociferous population due to their party politics was the second major cause for the poor participation in these villages.

The decision that their village is being dropped reached the village. The village leadership woke up, took pains to contact us in the hospital and promised that they themselves will take up the responsiblility of collecting jowar and assured at least 75% coverage of the village population for health insurance. Indeed, they kept their word this time. It was a lesson for us. We learnt that the more you share the responsibilities, more responsible the village leadership will be.

Steps Followed

The modus operandus for initiating the insurance scheme consists of the doctor and the ANM visiting the selected village. The villagers are gathered after one of the young boys goes around announcing on the microphone the arrival of the medical team in the village. To attract a good crowed, a slide show of general interest is arranged.

After the slide show is over, questions are elicited by the doctor and gradually, the concept of the health insurance scheme is introduced and explained, so also its operational details, its advantages etc. The doctor explains the need to the community. The villagers are then told about the amount of 'jowar' to be collected soon after harvest in December. The villagers are also told that the vaccination programme would begin a month later.

After this initial contact, the medical team leaves the decision to the village community about whether or not they want to be insured under the health insurance scheme. If so, the health insurance cards are issued to each household. Thereafter, the doctor pays a visit to the village once again to facilitate and supervise the jowar collection work. Before the vaccination drive is undertaken, an educational compaign is undertaken in the form of a slide show by the doctor. On the day of the vaccination drive, Village Health Worker goes around the village announcing over the microphone the time and the place where the vaccinations will be given, earlier agreed to by the community. Those who reach within predefined time at the vaccination booth only get the vaccine. If there are drop-outs, no attempt is made to either go door to door or increase the number of visits to mop them precisely because the medical team wants people to take decisions in time over matters of their need, 80% to 90% immunisation coverage of the susceptible population is essential to ensure prevention of an epidemic spreading in the villages. This new strategy has shown that it is possible to cover majority of the vulnerable children in the villages. The table 8 shows that in first year with this strategy it was possible to cover 95% children with measles vaccines, 505 with 3 doses of DPT and 79.4% with 2 doses of Tetanus Toxoid. In total of 5 visits, 75.2% children received 3 doses and more of polio vaccine and 43.2% received 5 doses of the polio vaccine.

TABLE NO. 8

VACCINATION COVERAGE IN FIRST YEAR (NEW VILLAGES)

ccine	Year	Target popula-ion (2 months to 59 months)	No.of villages	Number of mon-thly visits	Vaccine-doses received at the end of immunisation Campaign					
					Nil	1	2	3	4	5
asles	1983	315	8	1	15 (5%)	300 (95%)				
	1984		12							
T	1983	226	2	3	4 (1.7%)	45 (19.9%)	64 **(28.3%)**	113 **(50%)** 78.3%		
	1984	314	3	3	52 (916.5%)	47 (914.9%)	46 (14.6%)	169 (53.8%)		
al lio	1983	819	8	5 (3.9%)	32 (10.6%)	87 (10.2%)	84 **(12.4%)**	102 **(19.5%)** 74.6%	160 **(43.2%)**	3
	1984	317	3	5 (10%)	32 (11.3%)	36 (8.5%)	29 **(11.3%)**	36 **(15.7%)** 69.9%	50 **(42.3%)**	1
	1983	667	6	6 (1.4%)	10 (7.6%)	51 (10.3%)	69 **(10.3%)**	69 **(14.9%)** 80.3%	100 **(55.1%)**	3

The medical team also experienced that it is necessary to provide vaccination free lest the percentage of vaccination coverage suffers. The need for vaccination is not felt seriously by village community so as to pay money for it (see table 9).

TABLE NO. 9

VACCINATION COVERAGE

	Target population 10 years & above	Tetanus toxoid doses received by individuals at the end of the immunisation campaign		
		Nil	1 doze	2 dose
Tetanus toxoid to insured(free)	1659	197 (11.8%)	144 (8.5%)	1318 (79,4%)
Tetanus toxoid to non-insured (on payment)	230	173 (75.2%)	4 (1.7%)	53 (23.0%)

attempts to evaluate the cause for "drop-outs" from adequate vaccinatio
ealed, that in 80% of them it was due to ineffective communication on the par
the medical team. Hence from the next year as the vaccination target get
uced (only those born in last 1 1/2 year) the same strategy could achieve 80
adequate vaccination coverage (see table 10).

TABLE NO. 10

VACCINATION COVERAGE IN OLD VILLAGES (WHERE MASS IMMUNISATION HAS BEEN DONE EARLIER).

cine	Target	No.of Villages	Number monthly visits	Vaccine-doses received at the end of immunisation campaign					
				Nil	1	2	3	4	5
	314	7	3	3	12	18	281 (89.5%)	-	-
polio	340	8	5	4 (1.1%)	7 (2%)	11 (3.2%)	19 **(5.5%)**	36 **(10.5%)** 93.3%	263 **(77.3%)**
			6	1 (1.1%)	4 (2%)	9 (3.2%)	6 **(5.5%)**	25 **(10.5%)** 93.3%	162 **(77.3%)**
nus	1659	6	2	197 (11.8%)	144 (8.5%)	1318 (79.4%)			

The doctor makes the first visit to the village and launches the vaccination drive. Thereafter, it is the ANM and her helper who make the monthly visits and with the help of the VHW, complete the immunisation programme as well as take the weights of 1 to 5 year old children, keep the ANC and PNC records and take the weight of pregnant mothers.

The achievements thus could be summarised as follows:

i) Health sevices (Hospital+peripheral) have out reached the poor.

ii) It was possible to achieve herd immunity against vaccine-preventable illnesses (80-90% coverage). There is not a single reported case of vaccine-preventable illness in under fives since the mass vaccination started.

iii) A sense of ownership has been inculcated in the minds of people. The villages where this sense of ownership is missing, the scheme has not been imposed on them nor an attempt is made to persuade them. The health team has gracefully withdrawn and preferred to divert their energy on those villages where they are more wanted.

The Emerging Role of the Village Health Worker

The role of the VHW has evolved on the basis of the experiences of the medical team. The need for such a worker was felt since 95% of illnesses are self-limiting and can be treated locally. They require a symptomatic short term relief with simple drugs which a village health worker can administer. As a result, even an OPD that was started in one village was closed down as it was realised that the doctor was not necessary if there was a health worker in the village. What was important, however, was providing referral

services to the remaining 5% of the cases and seeking curative services from the doctor, as well as the hospital.

Earlier, the role of the VHW was seen as a limited one. The VHW was perceived as a link between the community and the medical team. The tasks involved were:

i) to dispense medicines for common ailments,
ii) to do quick referral of serious illnesses to the doctor,
iii) to run MCH clinic, and
iv) to assist the medical team in all their activities in the village.

Experience has shown that the acceptability of the VHW depends greatly on how much support the medical team can give him as a link between the community and the health delivery system. "It is imperative that the medical team should offer full backing to the VHW and should refuse to see patients when they come directly to the medical team. Psychological satisfaction of being treated by the right hands has a lot to add to symptom relief of the patient. At least patient's soul will rest in peace if he dies at the hands of an expert ! "VHW's limitations in the existing social structure must be realised and only specific responsiblities should be given to him. All his medical functions have to be under the close supervision of the medical team."

While the participation of the community is elicited in the selection of the VHW, experience has shown that if in a village meeting, an attempt is made to get a consensus choice, it is the articulate well-to-do villagers who dictate the selection of the VHW. What is found more practical is the selection of a less educated VHW from the poorer sections of the community by the doctor himself who sees the potential in the proposed candidate to do the kind of work that is expected of him. Presently there are 14 male and 1 female VHWs.

Initially the VHW was paid a stipend of Rs.25/- per month that was later raised to Rs.35/-. Realizing that if the VHW was paid by the medical team, the VHW felt more responsible to the team than to the community, it was decided that instead of the stipend, 35% of the jowar collection would be given to the VHW. In this manner, the VHW would become directly answerable to the community. What was found to be more feasible was to set aside a fixed quantum of village fund (35%) as the VHW's yearly remuneration, out of which 20% would be given in the beginning of the year, while 15% would be given at the end of the year, depending upon his performance. This would be decided in a village meeting in the presence of the visiting medical team. This would also provide the VHW personal incentive to insure maximum people under the health insurance scheme (so that the 35% share will increase) and ensure better work performance.

Of late, there has been further rethinking and question is asked whether the responsibility of supervision of VHW could be taken over eventually by the community. Towards this end, a need is now felt to delegate responsibilities to the village community so that the entire contribution that is received towards insurance from the villagers is given back to them as village fund. From this village fund the community would have to pay the cost of drugs for the VHW's kit, the fuel charges for VHW. The community would then decide how to utilize the rest of the funds, as well as assess the work of the VHW, rather than the doctor doing it. In this manner, responsibilities would be relegated to the community level and decision-making would get decentralized. This new strategy has been tried out this year and it remains to be seen how the community can be involved in managing their own village fund.

Yet another rethinking relates to the new role of the VHW. In the past one year, 2 villages had to be discontinued from the health

insurance scheme because the participation of the poorer sections had declined. It was realized that VHW plays a crucial role in acting as a facilitator and in establishing a link between the village and the hospital. In cases where the VHW was ineffective and unable to establish this link, there was not much increase in the percentage of the poor insured.

Earlier, the role of the VHW was perceived to be target-oriented and somewhat mechanistic. Certain tasks were required to be done by the VHW and these required minimum technical skills and hardly any formal training. There is now a growing realisation that the VHW must play a dynamic role and should be someone who is capable of organising men, women and youth around issues that concern them the most. Also he has to be a person who has the zeal and the aptitude for this kind of work and who requires minimal supervision. Viewed from this perspective, it is possible that some of the present VHWs would be found inadequate for the task and would have to be replaced by new recruits. However, this new expected role is not easy to obtain. "The incentive for putting soul in any endeavour can be either money, power, prestige or enjoyment of creativity. A VHW who comes from a poor and low caste is struggling to make two ends meet. He is yet to find his identity today. It is natural that to such a person money material incentive attracts first. In the process while they get more and more involved in the work some of them may enjoy prestige, power or satisfaction of creativity -- the essential for a liberator's role. But one must be modest and accept that majority of them may not reach this level because they may find it difficult to see beyond their immediate material gain."

The present thinking, therefore, is to select VHW from a middle class background, who will not be cowed down by the power groups in the village. He should preferably be one who enjoys credibility among all sections of the village population, so that his word carries weight in people's mind.

Non-Formal Education

The experience of working in Nagapur enabled the team to understand the irrelevance of their educational efforts. Being trained in the orthodox preventive medicine style, they organised talks on tuberculosis, leprosy, malnutrition, vitamin deficiencies, diarrhoea, family planning and the need for vaccination, only to discover that people were not interested in these talks.

The efforts to promote adoption of sanitary latrines did not evoke favourable response from the villagers who preferred open air defecation for various justifiable reasons. The vaccination programme suffered a setback because only 20-25% of the children were vaccinated. To counter the problem of malnutrition among children the team tried to sell sattu (pulse and cereal mixture) packets to mothers for 20 paise per packet. The effort was unsuccessful because the team realised that the mothers could not buy them because they had no control over the family income.

In order to ensure that women would have some money in their hands, various economic programmes were started but none of them met with any success. The dairying scheme was started in Nagapur but it was found that to become viable a switch had to be made to cross-bred cows and this meant that ultimately it was the middle and large farmers who benefitted. For the 'charkha' training, it was only the young, unmarried girls who came and in any case, did not earn more than Rs.3/- per day. Cost analysis of agricultural

produce or of possible cottage industry revealed that these alternative income generation programmes cannot survive in the competitive market in the absence of government protection.

But each of the failures became a positive learning experience for the team. What the team started to realise was what had seemed 'irrational' behaviour on the part of the villagers, was perfectly rational in the conditions of poverty in which they lived. Thus, the small family norm was unacceptable because each additional hand was an economic asset to the poor family. Unless a family has at least one male child they will not tend to accept family planning. In fact, they wait for two male children, as an insurance against unexpected calamity (thanks to high underfive mortality !) "Doctor, have you seen a bullock cart with only one bullock? You need at least a pair; if one succumbs at least the other will drag the cart on," said an old lady.

The problem of malnutrition was not due to the lack of balanced diet but due to poverty. It was futile to propagate the use of sanitary latrines when there was an acute shortage of water. In other words, an important principle that the team learnt was that it was not the villagers but they themselves, the urbanised, educated, middle class experts who needed to be educated about the realities of the rural environment.

An experience that involved a villager approaching the team to help him in procuring a bank loan became yet another learning experience. The bank agent had not signed the papers of the villager because he expected a share in the loan. The medical team took up the matter, approached the higher bank authorities and through their mediation enabled eight people in the village to get bank loans. After this episode, more and more people care to the medical team with their problems -- some came for procuring pump sets or for getting electric lines installed,

others for cross-bred cows, still others in connection with their local disputes. As the medical team involved itself in the priority problems of the villagers, they gradually earned credibility. They did not have to use various gimmicks to motivate villagers to come to their meetings. An announcement of the meeting was enough to bring them together for discussions that sometimes went on past midnight.

As the medical team introspected on their field experiences, they came to the conclusion that community health problems had deep socio-economic and political roots. They realized that concept of prevention of disease and promotion of health did not appeal to the people because in conditions of poverty, mere survival was their first priority. Health needs ranked low in their priority list: food and employment were much more important than health. They therefore realised that in conditions of poverty it was futile and even unrealistic to expect community participation and self-reliance in health care matters.

With this learning came the realisation that the medical education in the hospitals was inadequate in equipping the medical personnel with the knowledge, attitude and skills required to work in the rural areas. Medical education also kept the medical personnel ignorant about the socio-economic and political factors that constitute major obstacles in the development of appropriate medical care.

Yet another learning of the team related to the costly allopathic treatment often based on unscientific and unethical prescribing habits, improper selection of drugs and market oriented behaviour of the medical community. The team realised that as conscientious medical practitioners they should try to search for appropriate ways and means whereby drugs could be made

available to the poor people at cheaper cost. They got involved in the preparation of some common drugs that were locally prepared. These drugs, though not available in attractive packages, provided quality drugs at cheaper rates. These included skin ointments, eye and ear drops, cough mixtures etc.

Learning from field experiences thus became the guiding principle in designing suitable non-formal education strategies. With gradual expansion of work, the team has used this principle sometimes to get a discussion started after a Tetanus death of a woman in a village. At other times, he has been able to design a set of slides, posters, photographs on the basis of what has been seen, heard or commented on in the villages. As the villagers see themselves in the photographs and identify with the attitudes and beliefs, real life situations that are projected, through the slides and posters, the interest levels go up and feeling of involvement shows perceptible increase.

With regard to matters relating to malnutrition, immunisation of children etc, the experience has shown that it is important to design suitable non-formal education materials to explain the causes of various ailments and diseases, methods of prevention etc. in a style and manner that is comprehended by the villagers, particularly village women. The experience has shown that the educational materials must emanate from the people themselves and should reflect their beliefs, attitudes, superstitions and practices. The team has been able to develop a set of slide shows on these themes very effectively. As the slides are projected, a team member comments on them in the dialect that is locally spoken. Another popular method of initiating a discussion on health issue is through street theatre. The team has developed great faith in this.

The process of non-formal education, however, is seen as unfolding the social roots of medical problems. Viewed thus,

health is regarded merely as an entry point but it is recognised that it is problem of poverty that has to be attacked eventually. In order to do so, the team recognizes the importance of organising people around issues that concern them. Women have come together for a 'bhajan mandal'; farmers have come together to discuss remunerative prices for their produce and to express it through street plays. The search continues to bring people together on issues that concern them. In any event, the long term vision perceives the health problems as related to larger issues of development.

Finally, the role of the medical doctor is now perceived in a new light. The doctor can no longer be narrowly viewed from a medical perspective. Rather, the role transcends to take on the functions of an activist and a socio-political educator. While the doctor would play an important role in the curative aspect of primary health care, the preventive and promotive aspects would also have to be given attention by him. In other words, the role of the doctor in primary health care would have to be redefined.

Important Features

* Poorer sections of the population were willing to make a contribution according to their capacity towards their own health, but full self-reliance is a utopia.

* People's contribution enhanced their use of and demand over the health services.

* Deprofessionalization of medical practice and getting involved in people's daily concerns enhanced credibility for the health team.

* Recognising people's practices, myths and history as a starting point helped in health education.

* Use of critical personal experiences was made for learning.

* Use of local symbols, humour and ancedotes was made in preparing educational materials.

* The key role of Village Health Worker was recognized and supported by the medical team.

* Continuous self-analysis and critical reflection helped the team to design and implement a relevant programme.

* Availability of curative services in times of need enhanced the credibility of the health insurance scheme.

TRIBALS AND HEALTH CARE

Story of a Health Worker

It was in October 1978 that I visited Deogarh in search for a tribal village where I could work. This village on a high plateau with lots of dilapidated temples and huge castle, was quite enchanting. And that was the month when the area was full of greenery and lantana flowers.

I went around the area. The main village had few houses but lots of ruins, temples and castles. The habitation was spread in hamlets. Houses built on hill tops with narrow alleys and approaches were covered with country tiles. Tarnished and emaciated small 'Kutcha' houses were telling the story of the poverty of people in the area.

I talked to a young man on the bus stand to know more about the village and area. After a little hesitation, he told me the brief history of the village and other related things. Enquiries revealed that apart from the main village, all hamlets have tribal population. In fact, it was exactly the type of village I was looking for my work. I felt as if my dreams were coming true. I had nurtured hopes to work among tribals after reading about them in books. I decided right then that I would work here.

It was only in February 1979 that I could finally arrive at Deogarh. I arranged a room in a deserted castle for myself. My background of medicine was with me, and I was bubbling with enthusiasm and vigour. I always thought of working in the field of health and had visited several projects in the country. Even then my understanding of starting a health programme was limited and I was alone. The strong desire to work gave me strength in those moments.

The first four months I spent moving in villages, getting to know people, and collecting information. I saw tribals, lived with them, talked to them and learnt about their general health problems -- the poor hygienic conditions, uncovered children, exploitation, infectious diseases. Even after starving for two days, there would be a smile on their faces. A series of questions triggered off in me: What can I do here with these people? What kind of a health programme would work here? I thought hard and concluded that the best would be to start a simple dispensary. Some villagers were consulted. They happily agreed. A small house was rented in the middle of the village. A young enthusiastic village boy Chandra Shekhar joined to assist me.

The day was spent in treating the patients. In the evenings we both took off for different villages. The villagers, partly curious, partly enthusiastic, gathered to talk to us. Some came with their medical problems which we treated on the spot. Meetings were held in these villages. The people talked about their health problems. To my suggestion about starting a health programme of some sort, they seemed to agree. I was not sure what nature this programme would take. But I expected that whatever its nature, the people should participate in some way. I suggested that health committees be formed in each of the villages. The people seemed to agree. I did not check what they understood by such health committees. When I talked to people it looked as if everything would go on smoothly. People came in the meetings, talked and showed courage and interest to resolve their problems, or maybe my enthusiasm was such that slight interest by people looked as great enthusiasm. I also observed that there were people sick in other villages, but they did not come to the dispensary. There were reasons for their doing so and hence Chandra Shekhar and I decided to visit villages everyday. In the afternoon we would go to the villages.

Expansion

After eight months, we expanded the programme. A random survey was conducted to understand the general socio-economic conditions of people; their response towards health and how and what they can contribute to this programme.

In the meantime, we had established contacts with young men in several villages. Ideally we had thought of women serving as health workers. But there was no woman worker among us. Hence we could not motivate women to come forward. People with their traditional attitudes thought that men would be better workers for the purpose. Therefore, finally we had to choose young men. These men were literate. No literate women were available.

We drew up an ambitious plan and sought the reactions of our friends. Some suggestions were put forth and we suitably modified this plan.

Our plan included: maternal and child health, health and nutrition education, involvement of the local community in managing the health programme.

The young men we had chosen to be the village level workers were trained.

This training was carried out in a participatory manner. We touched upon socio-economic factors influencing health of the poor tribals. Besides this, I taught them basic medicine. The village health workers returned to their villages with a kit containing simple medicines and health education materials like charts and posters.

Village health worker system was a well accepted new approach at that time. I wondered why it was not working out here.

Six months later we analysed our work. We found that we had not succeeded in dealing with mother and child health issues. I could not figure out where we had gone wrong. I felt miserable. After some thought I realized that I had made the mistake of judging the villagers' general enthusiasm as a promise to cooperate. Health education had not proceeded well enough.

We were equipped in terms of training and other materials to effectively impart the health messages we hoped to do. The motivation of the people for such a health programme was also inadequate.

Our health programme had to face the socio-economic realities of the tribals in this area. It was not uncommon for a village to be completely cut off during the rains. Many a times, we could not reach out to the people because the whole hamlet had temporarily migrated to a different place -- a dam site or a forest clearing to find work.

We also tried to consciously talk to and involve the women. Our male workers did this with little success. But this effort proved fruitful for me as in that a lot of base-line data got collected. It revealed to me the mortality pattern of this area.

In spite of all these set-backs my team mates and myself decided to work on this programme for another six months. We decided to be more careful this time in carrying out our training, in communicating with the villagers and in promptness of providing the health service.

Review

A year later we reviewed our progress.

I was dismayed to find that there was not much improvement. I realized that the staff, as well as the village health workers and their communities, continued to be convinced of direct curative measures.

At this time we had started to encounter, and to deal with to some extent, several non-health issues facing the tribal people. These issues directly affected the socio-economic lives of the tribals.

One story that comes to my mind is about Raanpur village not too far from Deogarh. The forester living in the reserved forests on the outskirts of Deogarh rounded up the cattle from Raanpur and alleged that they were encroaching upon the forest lands. He threatened to confiscate the cattle unless the villagers paid a heavy bribe. Our workers were contacted by the villagers to help in this issue. We went to Pratapgarh with the people and succeeded in getting the D.F.O. to release all cattle without filing a case. The ranger and the forester were rather enraged.

Our health workers were bringing in such problems more often than actual health-related issues.

Slowly it dawned upon me and my colleagues that tackling health issues, however important they might be, while neglecting the social and economic issues of the community, would not be effective. We had to respond to and take up peoples' problems at large. We diversified into other organisational and educational activities. But surely this was not to be received pleasantly by the power holding and influential blocks in our area of work. We were opposed openly as well as slyly. We were branded sometimes as Christian missionaries out to convert the unassuming tribals, and sometimes as communists disturbing the peace of the area.

At the same time a feeling was growing among us not to worry too much about the functioning of the health programme. We felt the need to get involved in more basic issues confronting the tribal people. The disinterest towards the health programme was also because the hard and consistent work for two years did not bring any change in the health beliefs and practices of the community.

Some friends working in this area convinced us that the total movement for social justice alone could bring about desired change in people's concept of health. As a result, the health programme laxed. But because of the importance of health deliery we were hopeful that people would respond more towards the programme and it would take off sometime.

Another Review

In the beginning of 1982, we further evaluated the health programme. We discovered shortcomings. We found that we were not realistic in our approach and obsessed with its perfection. I too was under pressure. I had felt that I am accountable to the people, the funding organisations and it is my moral duty to implement the programme as planned. I felt I was all alone and there was no real support from other like-minded people. We also saw the possibilities of factors influencing the proogramme of which we were not aware of. The strategy for 1982 was planned. The emphasis was to be on curative work. Hence, we geared ourselves to consolidate our dispensary and sub-centres. Two trainings were organised, one each for village health workers and junior health workers.

Our concept of peoples' participation also changed. Previously we had expected the people to contribute financially, give advice to manage the programme, and support the health worker. By

1982 we had to redefine the peoples' role. We accepted that the delivery of curative health services through the local village health workers and senior workers is enough participation.

Alongside these changes, the degree of hostility from politicians and other powerful sections in the community was also increasing.

Our health workers were pressurized not to carry out this work. They were sometimes even threatened. In one remote village, Jholar, where health services were very essential a sub-centre was established. A local villager was trained as a health worker. The local thakur from a nearby village effectively convinced the local leaders not to support this work. In an organised manner, the Thakur forced the villagers to undermine the programme. The health worker was threatened to give up his work.

However, this did not succeed. The villagers were then threatened by their leader to ostracise the worker and refrain from receiving any services from him.

Government Support

During these months I was associated with one committee of the state government dealing with rural development. There I had been critical of the government's health policies for tribals. The government, in the middle of 1982, asked us to design some alternative programme of health care and examine its viability. We felt enthused and considered the offer. We felt the government support would minimize the false propoganda of our being disturbing elements. It would help legitimize our intervention. We then expanded the programme to a total of 15 villages.

The medical and health department suspended all its work in these villages to make way for us. But the powerful elements felt even more threatened now. They tried hard to prevent the government from letting us have this programme; but failed.

We built a more organised structure of health care programme. A three-tier system was evolved. The fifteeen villages were divided into 3 zones of 5 villages each. Each zone was looked after by a pair of middle level health workers. Each village had a peripheral worker (village health worker). The zones were coordinated by a central unit manned by me as a doctor and a couple of assistants. This unit was also responsible for planning, training, monitoring and evaluation.

We concentrated mainly on curative services. We concentrated mainly on providing effective services that directly benefitted the people. We organised curative services and immunization programme, disinfecting drinking water sources and surveillance of chronic communicable diseases like T.B., guinea-worm etc.

In all this, our effort was to practice rational therapeutics. We refrained from administering unnecessary drugs and injections. The people could not understand this. They were used to being treated through injections for even the minor ailments and were impressed by their apparently magic effects.

They were not satisfied with our practice. Besides, the village health workers were local youth and seen simply as lay persons by their communities. Initially it was difficult for them to accept them as agents of health care after just a brief training. Nevertheless, medical services which were previously inaccessible to the villagers became available to them at their doorstep.

Over a period of time the community started seeking the services of the village health workers and recognising them. We consistently gave importance and support to the health workers' services.

As our approach comprised of regular monitoring, we collected data to monitor the programme. We now knew about the incidence pattern of diseases, and mortality. We could thus plan our work accordingly.

In this way, we continued with our health programme. At the same time my colleagues from the local communities, who were sensitized to the issues of socio-economic exploitation, continued to address these issues of the people. The people too came to us with their problems. We inevitably got involved.

One of the major issues that we took up was that of the bonded labourers near our work area. With some support from the district government department, we were able to release several bonded labourers. This angered the local politicians and the higher-ups in the government. Following this, we started facing stiff opposition from all quarters for our health work too. The government finally brought its axe down on us. All our funds have been stoppd without any reason being given to us. Uncertainty looms over the health programme. The morale of the health workers and my colleagues began to sag. I was also confused and anxious.

The health workers are wondering whether they can continue to work. They are not sure of the peoples' support.

In spite of these vicisitudes we hope to continue because of our commitment to the people and not to some government whim. We want to rethink our strategy and plan a fresh one.

Health Care in Tribal Areas

Tribal areas are different than the plain areas and it is quite important to take these distinctive factors into consideration while devising any health system for these areas. These factors can be broadly seen as follows:

Tribals are ethnically different

The system of healing has evolved in three different ways: magic, religion and science. Throughout the time, human beings have devised ways and means of caring for the sick in community depending upon community's notions and empirical observations of origins and causes of ailments. Health problems in this context among tribals are problems arising out of a particular mode of living and its interaction with outside world. Most of the diseases in tribal community were attributed to supernatural causes and taken as the displeasure of gods, evil spirits supernaspirits and black magic. These beliefs are still held by tribals and hence faith-healers, magicians and practitioners undertake massive exorcising rituals on behalf of the sick. Among tribals, ailments can be classified in three patterns:

- those that can be treated by faith healers,
- those that can be treated by herbal and wild medicines,
- those curable by modern medicine.

Most of the diseases prevalent among tribals fall in the first two categories and are generally self limiting. There are only very few diseases which require specialised medical attention. This pattern of response has socio-

cultural roots among tribal community and which has transformed their behaviour in a particular way to respond to various health problems. Modern medicine is an alien system and most of the time it is not understood by the tribals. Hence there is no proper utilisation of the services and there is very poor attendance in health centres of tribal areas despite quite heavy morbidity. Nevertheless, there is some change in the attitude of tribals towards modern medicine, but most of it can be attributed to the rigorous health propaganda like malaria eradication, family planning and magic cure by allopathic practices like injections etc. But all this has not changed their basic attitude towards their health problems.

ii) **Environmental conditions of tribal areas are different and difficult**

Tribal areas are hilly and clothed with forest cover. This has led them to live in isolation from others. The terrain is undulating and density of population is also less than plain areas. The communication network is poorly developed and many areas become inaccessible during rainy season when health services are most needed. There is a need to take distance and village as parameters for developing health infrastructure, instead of population. Because of difficult living conditions people from outside are very reluctant to serve in these areas. The people who serve in these areas require a different orientation according to the environmental conditions of these areas. Looking at these environmental factors a very strong and well planned decentralised system of health care needs to be developed with a good referral system.

Tribal areas have largest concentrated group of people living in subsistence economy

Most of the diseases in tribal areas are related to the low socio-economic status of the people and underdevelopment of resources. Low income also accentuates the intensity of sickness. Mere availability of health service infrastructure cannot help to control these problems. The allopathic system is a very costly system and people having poor paying capacity cannot reap the benefits of it. The system also causes dependency on an alien system of medicine in which people do not have any knowledge and largely depend on the experts from outside.

The Model of Prayas

The situational analysis of tribal areas necessitates reorganisation of health care system to satisfy community's demands and needs.

Our work in PRAYAS was started with the above understanding. A professionally qualified medical person and two local youth who received in-service training, initiated work in 5 villages. They would first visit the villagers. In this meeting villagers were explained the need for selecting and training a local person of the village to look after their health needs. The villagers found it difficult to identify a person so they gave the PRAYAS team a free hand in selecting the Village Health Workers (VHW). The team had noticed a few potential people amongst whom they selected a VHW. All the 5 VHW's identified were male as the villagers were not convinced about having a woman health worker. The team also faced the practical problem of non-availability of materials to train illiterate health workers.

Training

After a selection was made in the five villages these VHW's were given an intensive training for 5 days.

The training was designed with the understanding that the primary need of the VHW's is to first establish his credibility with the villagers; therefore curative medicine was given a little more emphasis than preventive medicine.

The VHW was asked to list different diseases; which were then prioritised and the curative and preventive aspects of each of them was then discussed. Some time was also spent in discussing the mother and child programme.

In the training, local names of diseases were used and simple visuals utilised to make the training more relevant, interesting and effective.

There were no outside trainers. The entire training was handled by the core comprising of the doctor and the two local youths. After this initial training of 5 days, the VHW's went back to their villages with a small kit of medicines but a lot of confidence. In the villages also they achieved a new status. People came to take medicines and for the first time their problems were heard patiently and an attempt was made to explain what was wrong. After 3 months the VHW's met again for 5 days for more intensive training.

Slowly the health programme grew, the government of Rajasthan decided to support this programme in the beginning of 1983 so the number of villages increased to 15.

Work of VHW

The work of VHW included distribution of medicines for minor ailments, visiting houses once a week to find out if anybody was sick and needed medical attention, giving health education during these visits and to patients who come to take medicines. Flash cards and posters have been given to them for this purpose. They are reporting vital events to the centre at Deogarh. For this work an honorarium of Rs.50/- was given by PRAYAS.

Strengths and Weaknesses of VHW

Since all except one of the VHWs are able to read and write, they already enjoyed a certain status in their villages. Additional knowledge of medical work further added to their status and was a new source of confidence for them.

The distribution of medicines did fulfil a need of the people, especially those in remote areas. Otherwise they would have to travel long distances to Pratapgarh/Deogarh for getting medicines during times of illness.

The VHW became a point of contact for both the people and PRAYAS in the village. When they came for medicines they would naturally also spend a few moments talking to the VHW about their other problems. VHW became an important link with the village.

VHWs often did not stress the importance of preventive aspects of health care. They limited their work to that of distributing pills. They would visit the houses irregularly and during these visits talk of health education etc. Health messages given even to patients who came to the VHWs were sometimes incomplete or not explained effectively.

The importance of noting down vital events did not seem clear to the VHWs.

Even though the VHW is an important contact point for village people who talk about their other problems when they come to take medical treatment from the VHW, no system was set up to train the VHWs to systematically follow-up these socio-economic problems.

The selection and training of male VHW led to the neglect of the special medical problems of women who continue to make use of the traditional systems of medicine for their problems.

Woman VHW

Hirkibai is the only woman in the group and is the only non-literate VHW. She is from Lalpura village which is approximately 3 kms from Deogarh. Because of a closer relationship developed between the people of Lalpura and the PRAYAS team, it was easier to select Hirkibai as the VHW and for the people to accept her easily.

Hirkibai has helped women to understand the importance of giving colostrum to the newborn child. This in itself is a big change because for generations women in this area (as in most rural areas of India) do not give colostrum to their newborns because of the belief that it is stale old milk. Instead, the common practice in this area is to give the child goat's milk dipped in pieces of cloth or cotton wool. Today several women in Lalpura give colostrum to the babies.

The potential of VHWs to deal with the wider socio-economic problems in their villages cannot be overstated. Nathulal the VHW of Chinlad, along with a group of young men like him,

successfully counteracted the oppressive tactics followed by the village shopkeepers by helping one person from the village to set up a shop in the village itself. The group contributed the necessary capital and promised the new shopkeeper that they would patronise his shop only. The shop has been working well but lately the shopkeeper has been falsely accused by the forest guards that the wood used to make the furniture in the shop has been stolen from the forest. The guards threatened to put the shopkeeper behind bars for this. Nathulal and his friends are now getting ready to tackle the forest guards.

The villagers come and discuss a variety of problems with the VHW. The problems range from wanting to be treated for a particular illness to displacement due to the construction of a dam.

It has been noticed that both villagers and VHWs can hardly perceive the preventive aspect of health education. During the training VHWs were explaind that they could begin by giving medicines (curative) and then slowly start talking about the preventive aspect. They tried to do this initially but it never really took off. It was seen that whenever people would directly see the benefits of prevention, e.g. immunization, they took it up.

Senior Health Workers

In each zone of 5 villages, a senior health worker supports VHWs. The Senior Health Worker visits the village and helps out the village health worker whenever he has any problems. The subcentres are also used for referral purposes by the village health worker. Some of the Senior Health Workers are also involved in training VHWs.

All the Senior Health Workers are youth from in and around Deogarh. They have joined PRAYAS as the project grew. They have had on going and inservice training. A special five day training on rational therapeutics was also organised for them where doctors from outside were the main trainers. Another form of training is done through workshops and seminars organised by PRAYAS and other organisations in the country.

The Senior Health Workers, besides working on the health problems, are also involved in working on socio-economic problems faced by the villagers and in the other activities undertaken by PRAYAS.

All the Senior Health Workers and the VHWs meet twice a month and discuss their problems. They also formulate plans for the coming month.

The Senior Health Workers are highly motivated and are very interested in the work of PRAYAS. They are very enthusiastic about the work they are doing. They have a very clear socio-economic understanding both at the micro and macro level. they realise the importance of working in an integrated manner -- understanding that ill-health is a manifestation of the larger economic problem.

PRAYAS always wanted to train local people and encourage them to work for their own community and because of this in PRAYAS not just VHWs are from the local areas but practically all the people working in PRAYAS either on the health programme or on other activities are local youth. At present PRAYAS has a staff of 15 out of which 13 are local youth and 2 from outside.

Educational Processes

Education was an essential component for all activities undertaken by PRAYAS. A variety of adult education methods were used:

1. Informal Meeting and Conversations

This method proved to be the most effective; specially conversations which took place when villagers came to take medicines. Many times the villagers came from faroff places and liked to rest for some time before they started their journey back home. While they were resting they talked about their problems and the VHW also utilised this opportunity to discuss various aspects of health education. The atmosphere during these conversations was very informal and relaxed; hence it was possible to discuss delicate and personal issues which might otherwise be difficult. Once the problem was discussed and analysed, a plan of action was jointly formulated and implemented. After a particular problem was discussed at a personal level, many times the villager realised that it was not just his problem but the entire community's problem. This was then taken up for discussion, analysis and action in a formal meeting where the entire community participated.

2. Use of Puppets

A ten day puppetry programme was organised where health workers and other members of the PRAYAS team participated. The puppet shows were done during night after the villagers had finished their daily chores and they had some free time. Puppets were a source of entertainment

after a hard day's work and also serious topics could be dealt with in a light and effective manner. It was seen that the entire village community would come for the shows and would participate in the discussions that followed the puppet show. However, it was also seen that impact of puppetry as a media was limited. One of the reasons could be that in most of the cases the VHW never took the same topics for discussion again and hence there was no reinforcement and the villages could not see a link.

3. Use of Poster Exhibitions and Street Plays

Poster Exhibitions and Street Plays were also used to make the villagers aware of the health situation and its relation to their socio-economic condition. Its impact was again limited as there was not much followup done by the VHWs.

4. Surveys

Surveys were conducted to find out vital statistics and information. Surveys were conducted at the beginning of the programme and as the programme grew.

5. Training

The training of village and senior health workers became a major educational process in the project.

Lessons Learnt

Work in PRAYAS started through a dispensary but today health work forms just a part of their overall work.

1. The health programme, besides providing medical help to a population to whom medical facilities are not easily available, is used as a means to achieve the overall objectives of the project.

2. PRAYAS has been instrumental in getting bonded labourers released in their area; in addition, they have also been involved in other developmental and organisational activities from time to time.

   This work has threatened the existing power structure which has made all possible efforts to sabotage the work done by PRAYAS. As a result, a lot of time and energy is spent in trying to combat the existing power structure, and development of the health programme has suffered.

3. It is possible to develop a cadre of people from the local area to work at the village level; it is also possible to use their practical experience to develop a theoretical understanding of their work.

4. Sustained follow-up discusstions, reinforcement, action, demonstration is required for health education messages to be effective. Despite the tremendous amount of work put in by the PRAYAS team in puppet shows, street theatre etc. The impact has been limited. Though large crowds gathered to see the shows in the villages and a discussion was held immediately afterwards, and people unerstood the message that was sought to be given through the performance, it was forgotten the next day. For people, these shows remain as a good source of entertainment. Changes in health behaviour can occur only if sustained follow-up is made.

Important Features

* An initial familiarisation and learning period was essential before people's real health needs and practices were understood.

* Working on issues other than health brought credibility and accessibility; but it also politicised health work and generated local retaliation.

* Tribals had a system of cure based on faith healing and herbal medicines which needed to be understood before new information could be imparted.

* Mere use of puppets and street theatre communicated informtion but did not result in changes in health behaviour.

* Government support for the programme made it pre-programmed; and, tribals did not accept programme's planning.

* Local youth trained as village health workers became important educators and organizers of the people.

MATERNAL AND CHILD HEALTH

History

CINI - Child in Need Institute -- was started in September 1974 in the slum and village areas around South Calcutta with the prime purpose of providing the much needed health care services for poor mothers and children living in conditions of abject poverty.

Initial training of village health workers who were mostly selected by the community was started. Training was mostly on the job; learning by doing and with periodical formal sessions. In the year 1977, CINI continued the mother and child care health services in the villages and in the slum areas but started looking at its objectives in a broader sense. Besides the paediatric ward serving severely malnourished children and the Nutrition Rehabilitation Centre (NRC), a few new activities like functional literacy, limited activities in skill training, income generation for mothers were also incorporated.

The following year, 1978, more beneficiaries were covered by the functional literacy programme and a sponsorship programme was started to provide educational opportunities to needy school going children.

CINI decided to couple agricultural activity with mother and child activity and with this hope purchased a plot of land to convert it into an agricultural farm. This was supposed to serve dual purposes: firstly, to raise the income of the Institute as well as to feed the malnourished children at the NRC; secondly, it could serve as a model agricultural farm to train villge farmers and to help poor mothers by its extension acivities.

The government of West Bengal recognised CINI's expertise in training the mother and child health (MCH) workers and requested it to extend its training activity to cover government sponsored Anganwadi workers of the Integrated Child Development Services (ICDS) projects.

As a part of the development programme, CINI, through sponsorship programmes started repairing village schools, providing teaching aids etc.

Its activities now include rehabilitation of the severely malnourished children, health education of motors, supplying low cost food supplement to malnourished children and mobile under five's clinics in the villages.

In 1981, for the first time, CINI felt the importance of organising women's groups (Mahila Mandal) and started Balwadi centres (Day Care Centres) in the villages and encouraged women to take up income-generating activities.

At this stage the objectives of the Institute were defined as follows:

1. To develop and impart a community based, low cost, comprehensive health care programme to raise the nutritional and health status of children and mother.

2. To organise mothers into effective groups (Mahila Mandal) through a systematic process of education and awareness creation and to initiate group action prorammes to tackle commom issues.

3. To raise the economic status of the family by providing mothers with an opportunity to supplement income by taking up activities at the family level.

4. To train more and more health and development workers from both the governmental and non-governmental sectors who will then work in health and development projects at various places.

The Institute's activities at the field level are guided by the first three activities which essentially call for programmes in the areas of health and nutrition, awareness creation and income-generation. CINI felt that development is basically a human problem and a lot could be achieved if the infrastructural development and social development could go hand in hand.

The efforts during 1982 have been primarily in organising village mothers into cohesive groups with specific action programmes to meet their common needs. This became the first step in transferring various activities of the Institute on to the community.

Community level activities like road construction, repairing, sinking of tube-wells, training of village mothers, balwadis, saving schemes, income-generation activity were directed through the Mahila Mandal. Mother and Child care services were strengthened at the community level through the participation of women.

Health Programme

All programmes in CINI are geared towards improving the health status of the mother and child. In the health activities, the major focus is educating the mothers around the health and nutrition aspects. Certain health programmes, unique to CINI, are discussed in detail here.

The health programme in CINI is characterised by:

1. Clinics which are of four types: Static, Zonal fortnightly, Mobile weekly and Daily.

2. Paediatric ward and Nutrition Rehabilitation Centre (NRC).

I. Clinics

Static Clinic

This clinic is run once a week in the CINI campus where mothers come with children from quite some distance. About 500-600 children come here every week. They are examined by the village health workers who are the main persons responsible for this clinic. The doctors play a mere supportive role. They are around to help with any problematic cases.

While the mothers await their turn to be examined, the child's weight is noted down by some of the village health workers, at the same time groups of VHWs are also moving around talking to the women about nutrition, oral rehydration, health care. They do this either at the one-to-one level or a VHW talks to three or four women.

The VHWs have local nutritive foods spread out in a plate and they take this to the mothers and explain to them the value and importance of the food. Personal contact and practical demonstrations help these rural mothers to remember and imbibe the learnings. Besides practical display, charts are also shown.

CINI has also developed a highly nutritive cereal pulse mixture which is called Nutrimix. Nutrimix is prepared in front of the mothers during clinic time, who watch this while they are waiting in the queue. Each child is also given some amount of Nutrimix to eat. It is done so that the mother sees her child eating this and is motivated to make it at home for her child. She can also buy this mixture from CINI at a nominal rate of 50 paise per packet. All she has to do then is go home and heat the mixture up with a little water. Today mothers in the project area have realised the importance of Nutrimix and they buy these packets and give it to their children.

One part of the clinic is marked out for immunization. Here again it is the VHWs who run the show. There is also a section for post-natal and ante-natal care.

Zonal Fornightly Clinic

These clinics are run by VHWs in the field and are supported by the Mahila Mandal mothers. It is important to understand how these Mahila Mandals were formed and at present what role they play in the clinics and in their own communities.

Mahila Mandals

The process of forming Mahila Mandals started 5 years ago. The initial months were spent in visting houses, meeting mothers, talking to them about general things. While doing this, the community worker gauged the interests of the mother and then went and spoke to the other family members so that they do not feel unorganised when the women start going for meetings.

The date, time and place to meet was discussed and decided along with the mothers. When they met as a group, a number of weekly meetings were planned. These dealt with the awareness creation, education and health aspects. The scope of the discussions was limited to the family and village level which was essential to sustain the interests of the women. During the sessions, different methods like puppet show, posters, slide show, using a cassette to narrate a story, inviting a resource person, etc. were used. The last two sessions dealt with the organisational aspect of Mahila Mandal; how they should go about forming a Mahila Mandal, what they want to do in a Mahila Mandal, etc. At the end of about 10 sessions a Mahila Mandal was formed.

Initially it was thought that these sessions would be once a week. Often this did not happen for a variety of reaons; sometimes the women were busy in the fields or because of the involvement of CINI in other activities, it was bit possible to get enough people for a puppet show.

The groups were usually formed around certain concrete programmes like running a Balwadi, a sewing scheme, literacy classes in some places, income generation activities in other places. The women were helped to consolidate their group and run these programmes in an effective manner. While doing this, some problems arose.

One problem was of choosing wrong leaders, women who were not interested in the development of the group but were hampering it. To this problem the women reacted in different ways. When the Mahila Mandal was split into two, it was seen that the new group was very strong and determined as they had struggled to form this group. In

some cases, the women could not do anything about the wrong leadership as the leaders were powerful women of the village. In some other cases, there was a lot of infighting in the group and the group was not in a consolidated form the women could not do anything about it. In one case, a group which was very strong got affected by the change in the field worker of CINI.

After working on concrete programmes mentioned earlier for about 2 years, the Mahila Mandal mothers gradually started getting themselves involved in helping VHWs during their home visits or in the clinic.

The Mahila Mandal mothers are mainly involved in preventive and promotive child care. The mothers visit other houses, speak to the mother about the importance of oral rehydration solution, the importance of feeding the child when he has diarrhoea, nutrition, education, etc. She does this by practical demonstrations or through one-to-one talk. Her role is mainly to support the VHW.

The Mahila Mandal mother tends to be more effective as she herself is a mother from the same community.

The Mahila Mandal mothers also help the VHWs to run the fortnightly clinics in their own zone. In these zonal clinics a doctor from CINI used to earlier go once a fortnight whenever the clinic was held; but now he goes only once a month and the rest of the time the VHWs and Mahila Mandal mothers manage the clinic on their own.

The medicines for the clinic are provided by CINI. Some basic medicines are kept at the centres and vaccines are taken on the day of the clinic.

The Mahila Mandal mothers have been working in this way since some time. They did not receive any formal training, but health issues are discussed in their group meetings. Since the last eight months, an attempt is being made to provide a structured training of 10 days to a batch of 25 Mahila Mandal mothers at a time.

Mobile Weekly Clinic

These clinics are held once a week where a team of VHWs and a doctor along with medicines visits a particular place once a week. The same pattern of health education is followed, and these clinics are mainly run by the VHWs with the support of the doctor.

For all these clinics, the mothers have to initially pay Rs. 1.70 to get a card, after which they have to pay 70 paise per visit.

Daily Clinics

This clinic is run in the CINI campus every-day in the mornings and evenings, where a doctor and a few VHWs are present. This clinic is on a much smaller scale. The health education aspect is not emphasised very much here. Emphasis is on treating the child.

II. Peadatric Ward and Nutrition Rehabilitation Centre (NRC)

A part of the CINI campus building has a small Paedatric ward of 14 beds where children in serious malnutrition condition are admitted. The mothers accompany the children and stay with them. They are helped by the nurses to look after their children and feed them. While they are

there they learn about health practices; they learn this because they are doing it everyday.

When the child is feeling better and has passed the critical stage, she is shifted to the Nutrition Rehabilitation Centre (NRC); here the mothers play a more active role as the child does not require as much attention.

A typical day at the NRC could be described as follows:

A day at the NRC starts at six in the morning when mothers clean the NRC. Later they prepare Nutrimix for the children and tea for themselves, by 9 a.m. They have finished their bath and breakfast.

They start preparation for lunch under the guidance and supervision of the attendents. Responsibilities are divided amongst the mothers in terms of cutting, grinding, cooking, cleaning and serving. While they are doing all this, the attendants are constantly talking to them and discussing with them how best things should be cut and cooked so that they do not lose their nutritive value.

Mothers at the NRC cook not only for themselves and their children but also for mothers in the ward. The weekly menu is set by the nutritionist. Lunch is prepared by 11.00 a.m. after which they again clean the kitchen.

The mothers are free till lunch time so the VHW uses this time to talk to the mothers about mother and child health, cleanliness, etc. Each health worker is responsible for 4-5 mothers. When the nutritionist and the doctors go on their round, they talk to the mothers to find out the

amount mothers have been able to retain from what the VHWs has said. All the mothers first feed their children, later they sit in a circle and have lunch togther.

After lunch the nutritionist, the VHWs, attendants, mothers all sit to discuss certain health and nutritional aspects. A variety of methods like role play, slide show, bioscope, practical demonstration, group discussions, etc. are used. This session is for about 2 hours after which they start preparing for dinner.

Before and after dinner is the time when the attendants again talk to the mothers. There is a lot of informal dialogue as the attendants live with the mothers.

Evening and nights are the most crucial times as this is the time when everyone is free and relaxed. This is the time when many personal problems of the mothers come out and the attendant tries to handle this at her level. If she feels she cannot do this, then she talks to the other staff of CINI. While talking about general family matters, the attendants use this opportunity to also talk about health and nutrition.

Village Health Workers

Besides being involved in the clinics, the VHWs visit the villages and make home visits and maintain their contacts with the mothers and children. They are helped in this by the Mahila Mandal members. In this way they are in constant touch and refer serious cases to the CINI campus. At present there are 34 VHWs spread over the 5 zones covering 40-50 villages; on an average there is one VHW in one village. They get regular in-service training when they

meet once a week as a whole group where they discuss their problems and also a new educational input is given to them.

Besides providing training to VHWs and Mahila Mandal mothers, CINI also conducts training for Traditional Birth attendants, Villge practitioners, Youth members and School teachers.

All these trainings are geared towards improving the health of both the mother and child and popularising the idea of preventive and promotive child care.

Lessons Learnt

1. Mahila Mandal mothers are from the community and as they themselves have gone through health care practices and experienced its positive results, they are very effective in explaining to other mothers, who in turn find it easier to understand and accept from these mothers. It is possible to cater more effectively when local mothers are involved as the work of the VHW gets shared. Mahila Mandal mothers can maintain contacts with 4-5 families around their houses and in this way personalised and close contacts can be maintained in the whole village.

2. A lot of time was spent in organising and making the Mahila Mandal strong. The mothers first disucussed and worked on general issues and programmes, activities which were most pertinent to them. Later they moved on to health issues. The move was gradual and slow and emphasis was on consolidation of the groups. Today the Mahila Mandal mothers play an important role in health care.

3. Learning through practically doing is a very effective form of learning for illisterate mothers. As these mothers spend most of their time in doing, they also learn best by doing. This was realised and put into practice at the NRC where mothers learnt about health education and hygiene by participating in the whole process whilst their children were being rehabilitated.

4. Optimum utilisation of time is made. Inputs regarding health education are given while the mothers await in the queue for a check-up by the VHW. The mothers do not resist this input as they do not have to spend any extra time from their busy schedule.

5. Mother and child are a part of the larger community. In order to improve their health conditions work has to be done with the entire community. Only when the whole community is involved can there be an impact.

   Health is related to economic factors and if something has to be done at this level pressure groups have to be created which can be promoted through community participation.

6. Role plays provide a lively and realistic way of practising skills that involve working with people. It is especially useful for training persons who are more used to learning from lie than from books.

Role Play on the Importance of Breast Feeding and not Bottle Feeding

Performed by VHWs **Time : 10 Minutes**

First, the main characters introduce themselves
Their names are:

RITA	:	The Village Health Worker
AJANTA	:	A rich woman, but vain
MANJU	:	A poor woman, but modest
SITA	:	A poor woman, but prudent.

One day Manju and Ajanta meet in the street. They stop to chat about their babies. Both babies were born during the same week and both look beautiful and healthy.

Sita arrives with her baby - who also looks healthy and is also of the same age. The 3 mothers compare how they feed their babies.

Manju has decided to bottle-feed because the radio says it is better.

But she admits it will be a sacrifice to buy the milk and she might have to add a lot of water to it.

Ajanta says she bottle-feeds her baby because it is more convenient and so her breasts won't sag.

Sita does not agree. In her family, breast-feeding has always been the tradition. She insists that breast-fed babies grow health and strong.

Manju and Ajanta laugh at Sita. They say she is old-fashioned because she does not bottle feed her baby.

But let us look at the babies one month later.

Manju and Ajanta meet each other in the street and notice how thin and sick their babies are !

Ajanta explains that her baby has had diarrahoea a few days back and does not seem to be getting better. Right now she poops (she shows her happy).

Manju says that her baby has also got diarrhoea and right now she poops. What can the mothers do with these thin, skinny and sick children?

Just then Sita comes by. Her baby looks strong and healthy. It has grown a lot. The other two mothers look at it jealously. Manju suddenly realises that bottle-feeding might be the cause of diarrhoea. She wishes she could breast-feed her child - but it is too late. Her breasts have dried up. But Sita tells her about an aunt who started to breast-feed her baby again after her milk had gone dry.

She suggests that Manju speak with Rita, the health worker to see if she has any advice.

Manju is eager to talk with Rita. She asks Ajanta if she wants to come with her. But Ajanta says, 'Not me' and leaves to buy medicine for diarrhoea.

Manju visits Rita and explains her problem. Rita gives her four suggestions:

- Drink a lot of liquid;
- Eat as well as possible - eat as much as you can green leafy vegetables, rice, dal, etc.;
- Get plenty of sleep;
- Put the baby to breast before you feed other foods.

Manju is eager to try these suggestions.

Let us try to look at the baby after 3 months.

Manju and Sita meet in the street and notice Manju's baby - who is now healthy and grown up.

The 2 mothers are happy to see their children so healthy.

They realise that it is because they are breast-fed.

Just then Ajanta arrives. In the meantime, Ajanta's baby has died. With sad eyes she looks at Manju and says,"How foolish I was not to have breast-fed my baby. If I have another baby I will breast-feed him".

Bottle-feeding Causes Diarrhoea

Breast-feeding Keeps Baby Healthy.

Questions to ask mothers after presenting this role-play:

1. Does this problem exist in our community ?

2. Could the children or families here make a similar survey ?

3. What do you think of this idea for presenting the results of the survey in a short visit for the entire community ?

4. What else can be done to help to solve the problem ?

Important Features

* Women learnt a great deal when education was supported by a strong service component.

* Women's groups were formed to take up wide economic issues, and health became one of their concerns then.

* Local women trained as VHW were effective, along with mothers belonging to Mahila Mandals, in influencing other mothers in the villages.

* Women learnt about health and nutrition by actually practising new behaviours - learning by doing.

* Local health practices that work were accepted and built upon.

* Educational aids were used as a part of the overall educational strategy.

NON-FORMAL EDUCATIONAL PROCESS

The analysis of the case studies presented earlier highlighted a series of key aspects about the educational process used in sustaining peoples' involvement in various PHC activities. Much of this educational process is of non-formal nature and relates to adults in their own context. In this section, some important aspects of this adult non-formal educational process are summarised.

1. People's involvement is initiated and sustained through an educational process when it is two-way in character. It became clear in the five case studies that health workers, doctors, project staff -- all involved in promoting health programmes, their continuous reflection, monitoring and evaluation, their periodic testing of assumptions underlying their programmes in the light of their practice -- these elements seem to reinforce people's own learning, change and involvement in the health programmes. As it became very clear in the NNH and SRED examples the process of self-reflection jointly undertaken by the staff and the people created the basis for people's own initiative in matters of their health.

2. In all the five case studies, ordinary people - women and tribals and farmers - were first accepted as they are. The people's existing actions were <u>not</u> evaluated as irrational and stupid; their health practice was first understood in the context of their own rationality, and not that of the project staff. Once their health attitudes and practices were understood, then the people were helped in exploring roots of their practice and attidues. This initial suspension of judgement by the experts helped the people to feel accepted as they were. Based on their

exploration of the roots of their attitudes and practices, it was then possible to encourage them to develop new insights and practices. At the same time, as has been shown in the case of NNH, 'naming' of what was not said - calling a spade a spade - was seen as an important step in assisting people to examine their own fears. This process of naming helped the people to articulate their fears regarding health and ill-health, thereby making it possible to deal with those fears.

3. In all the cases, a starting point was to recognise and value people's existing knowledge about health care. In matters of child-rearing and herbal medicines, and home remedies, people were encouraged to articulate what they already know and do, and this was carefully documented and recorded. With the help of programme staff, this existing knowledge of the people was systematised and revitalised. People were then encouraged to assess their knowledge, to identify gaps is their knowledge, and to acquire new knowledge, in order to sustain their health. This educational process of helping people to articulate what they already know, and to critique that knowledge, was necessary before people could acquire any new knowledge.

4. The context of the educational process was largely a collective one in most cases. Strong women's groups and organisations formed in case of CINI, SRED, and NNH assisted in furthering the educational process for the women as well as for other women in the community. The very linkage of educational process to the collective made individual learnining exciting and meaningful. When members of women's organisations took initiative for furthering their own education, as well as promote health

education among women of their village or slum, the learning process was faster and more effective, and the changes in health attitudes and practices more visible.

5. The educational process was most effective when individuals became the focus of communication, and not mere consumers of information. This, however, was possible because of a climate of mutual support and learning that the educational process created. People learnt best from their immediate and concrete experiences; they learnt best when chronic health issues were viewed as crises; and they learnt best when concern was on solving the immediate health problems. This use of experience as a base for the educational process highlights the experimental nature of non-formal education.

6. Learning by doing -- actually doing -- was an important aspect of changes in health attitudes and behaviours. This was most dramatic in case of CINI where mothers learnt how to look after their malnourished children. Thus non-formal education process can enhance people's responsiblity for their own health if it encourages them to learn by practice.

7. Non-formal education promoted people's involvement in health care more significantly when it dealt with diverse groups in a distinctive manner. In all the cases, groups were organised on class and gender basis. The poor men and poor women were organised separately and the educational process dealt with them in a distinctive manner. Women were helped to deal with their own health concerns before they were brought in interaction with men's groups. Women of different age and a life stages were dealt with

differently -- young girls and elder widows needed different focus and methods of education. This is best highlighted in the case of SRED. But variations in the educational process to suit particular homogenous groups was a key characteristic. In fact, educational process varied with the level of organisation and development of the group and the nature of leadership in the group. Hence the educational process both focused upon issues of leadership and organisation as well as varied itself depending upon the nature of leadership.

8. The very nature of non-formal education is such that it promotes people's involvement in a variety of areas of their concern. In all the cases, people's involvement in issues of health became stronger as their involvement in other social and economic issues grew. This was almost simultaneous in the case of NNH; health became a starting point in case of SRED; health grew out of an initial involvement in social and economic issues by women in case of CINI; and involvement in health lead to involvement in other issues in case of PRAYAS and Sevagram. It is perhaps not necessary to accept or reject the theses of health as an entry point. What is more important is to see how people's involvement is catalyzed and sustained through an educational process that does not remain limited to health alone. The process of analysing, planning and solving the problems is based on an educational process which people acquire, which can then be applied to a variety of issues. This flexibility and comprehension that health alone not be the ultimate area of people's involvement helps in promoting an educational process that supports involvement.

9. The educational process entailed in building Village Health Workers (VHWs) within the community was most

dramatically highlighted in three examples (CINI, SEVAGRAM, and PRAYAS). In each of these cases, VHWs were trained through a combination of structured sessions and ongoing practice in the fields. It was clear that the educational support provided to the VHWs by the medical personnel became a key element in their effectively performing their role. The educational role played by the VHWs themselves became crucial in their ability to sustain peoples involvement in maintaining their own health. Thus educational process in preparing VHWs and in the practice of VHWs -- both -- was important in sustaining people's involvement in their own health.

10. The case studies also demonstrate that community involvement in and learning about health care was significantly facilitating with the presense of supportive curative services. It is important to recognise that in the concrete context of people, and poor people in particular, health becomes a concern only when illness is there and curative health services are needed. An educational process that does not recognise this reality of the people and that is not supported by such a curative programme will remain ineffective. This does not imply that curative services alone should be given priority. But community involvement in health care can be carried out with preventive and promotive aims, but supported by curative services. An educational process geared towards those two aims will not succeed in the absence of the support of curative services.

11. The case studies also bring out the importance of the use of educational aids. These comprise of slides, charts, role plays etc. It appears that effectiveness of these aids is enhanced if they are used as a part of an overall

educational strategy and not just to "dump" information on the people. An educational strategy that considers people as a focus of communication, and not mere consumers of information, can effectively promote the use of various aids.

Moreover, educational aids prepared from local experiences, anecdotes and symbols, and using local history and humour are really much more effective than any pre-designed aids. This was highlighted in case of SRED, NNH and Sevagram very clearly. It highlights, therefore, the importance of using the educational process to build local capability in designing aids as a way to sustain people's involvement educational aids, pre-designed aids will dominate the educational process.

12. Finally, the five examples also highlight, the varying nature of community involvement in Primary Health Care. The extent and form of this involvement seems to vary with the context, the people and the nature of the health programmes. Therefore, any insistence on a common form and nature of community involvement may be unnatural. Despite this diversity, the case studies bring out a basic common thrust of community involvement - people are the end, the subject and the focus of this involvement. Thus people are not tools to be manipulated for involvement, but are the centre of this involvement. It became obvious that Primary Health Care programmes which put people in the centre also use an educational process which puts people in the centre and builds upon their subjectivity.

The above characteristics highlight the critical and distinctive nature of the educational process. It describes and clarifies how educational process can be carried out in PHC in order to promote community involvement. The case studies demonstrate this educational process very lucidly and the summarisation above puts a conceptual framework to it.

ABOUT US

Society for Participatory Research in Asia (PRIA) is a non-profit, voluntary organisation registered under the Indian Society's Act.

Participatory Research is a methodology based on the belief that knowledge is power and, therefore, can contribute towards the empowerment of the poor. It promotes the involvement of the poor and oppressed, their organisations and representatives in the creation and utilisation of knowledge in their own collective interests. It thus attempts to challenge the monopoly over knowledge and its tools in the hands of the few.

We work with local groups and activists involved in struggles of the poor and oppressed.

'PRIA' provides this support through training, research, evaluation, bringing together groups on common issues and preparation of learning materials.

We are a team of ten persons working with partner groups all over India.

In the last four years of its existence, PRIA has specially focussed on primary health care, adult non-formal education, problems of deforestation, land alienation, women's income generating and occupational health hazards. Besides this, workshops and training programmes on relevant themes have been organised as per the needs of partner groups.